Calendar No. 140

99TH CONGRESS
1st Session

SENATE

REPORT
99-62

INDIAN HEALTH CARE AMENDMENTS OF 1985

MAY 16 (legislative day APRIL 15), 1985.—Ordered to be printed

Mr. ANDREWS, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 277]

The Select Committee on Indian Affairs, to which was referred the bill (S. 277) to amend the Indian Health Care Improvement Act of 1976 having considered the same, reports favorably thereon with an amendment (in the) nature of a substitute and recommends that the bill (as amended) do pass.

PURPOSE

The purpose of S. 277, the Indian Health Care Amendments of 1985, is to reauthorize the Indian Health Care Improvement Act of 1976 through fiscal year 1989, to make amendments to the Indian Health Care Improvement Act, and to authorize appropriations to carry out the provisions of the Indian Health Care Improvement Act.

BACKGROUND AND NEED

The Indian Health Care Improvement Act of 1976 and the Snyder Act of 1921 comprise the basic legislative authority for the health care programs that are administered by the Indian Health Service, a bureau of the Public Health Service within the Department of Health and Human Service. The Indian Health Care Improvement Act of 1976 was amended and extended in 1980, and was scheduled to expire on September 30, 1984. The provisions of the Act were extended through September 30, 1985 by Public Law 98-473, a joint resolution of the Congress making continuing appropriations for the fiscal year 1985.

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Although significant gains have been realized in improving the health status of Indian and Alaska Native people since the passage of the Act in 1976, health status parity with the general United States population has yet to be achieved. Infant mortality, a critical health indicator, is 11 percent higher among native populations than the rest of the American population. Tuberculosis among Indians and Alaska Natives is six times higher than the national average. The incidence of chronic liver disease, diabets, pneumonia, influenza, and hypertension among Indians also greatly exceeds national averages for all other races. Recent epidemics of bubonic plague among Indians in the Southwest and of Hepatitis-B among Alaska Natives are further evidence that diseases long ago eradicated from incidence in the non-Indian population continue to afflict Native Americans.

In exchange for lands ceded to the United States by Indian tribes under the provisions of treaties, executives orders, and various acts of Congress, the Federal government has provided health care services to Native Americans since the early nineteenth century. Federal programs for the benefit of American Indians were first administered by the U.S. War Department, but in 1849, the responsibility for the provision of health care to Indian people was transferred, along with the Bureau of Indian Affairs, to the Department of the Interior. In 1921, Congress enacted the Snyder Act, creating the first legislative authorization for appropriations for the "relief of distress and conservation of health" of Indian people. Later, in 1955, the responsibility for the provision of health care services to Indian people was again transferred, this time to the Division of Health in the Department of Health, Education, and Welfare under the authority of an Act of Transfer the Maintenance and Operation of Hospital and Health Facilities for Indians to the Public Health Service. The Division of Health subsequently came to be known as the Indian Health Service within the reorganized Department of Health and Human Services, where the responsibility for Indian health care continues to be vested.

In response to findings that the health status of Native Americans was significantly below that of the rest of the United States population, Congress enacted the Indian Health Care Improvement Act of 1976 with the stated goal of raising the health status of Indian and Alaska Native people to the highest possible level. The Act authorizes additional funds (supplemental to the base appropriated for the operation of Indian health programs) to reduce unmet health care needs and existing backlogs in health care services, and establishes programs to increase the number of Indian health professionals, and to provide direct and referral health care services to urban Indians. The Act was amended in 1980 to provide appropriations authority through fiscal year 1984 and to make certain amendments to the Act.

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The Indian Health Service operates the largest direct health care delivery system within the Department of Health and Human Services, with over 11,400 permanent employee positions. The Indian Health Service administers health care programs to Indians and Alaska Natives through eight area offices and four programs offices, each of which has the responsibility for the provision of health care services within its respective geographic area. the area offices and program offices also have responsibility for overseeing the administration of Indian Health Service service units, the most local administrative entity, through which services are provided directly or by contract to the eligible Indian population. Each service unit may include one or more Indian Health Service hospitals, health centers, school health centers, health stations, or health locations. A health center is a facility that is open a minimum of forty hours per week and offers acute and chronic care services on an outpatient basis. A health station is a facility that may be mobile and which provides outpatient services on less than a forty hour per week basis. A health location is a site for the periodic provision of outpatient health services often provided by traveling health care professionals Where no Indian health Service facility exists or where an Indian Health Service facility lacks the capacity to provide certain types of health care services, the Indian Health Service contracts with private health care providers for the provision of health care services to indian patients. The Indian Health Service also provides technical assistance in the construction and operation of sewage treatment and clean water facilities.

With the enactment of the Indian Self-Determination and Education Assistance Act in 1975, Indian tribes, tribal organizations, Alaska Native communities, Alaska Native regional health and village corporations have begun to assume the responsibility for the provision of health care under contract with the Indian health Service. In addition, Indian Health Service programs, such as the Community Health Representative program, that are administered directly by Indian tribal governments have done much to heighten awareness of the importance of preventive health care and health education in Indian communities.

To ascertain the need to reauthorize the Indian Health Care Improvement Act of 1976, the Select Committee on Indian Affairs held six hearings in 1983. Hearings were held in conjunction with the House Interior and Insular Affairs Committee in Phoenix, Arizona on March 31, 1983. The Senate Indian Affairs Committee held separate hearings on the need for reauthorization in Grand Forks, North Dakota on June 2, 1983; in Anchorage, Alaska on June 3, 1983; in Seattle, Washington on June 8, 1983; in Billings, Montana on July 8, 1983; and, in Washington, D.C. on July 28, 1983. The Committee received testimony from Indian tribes, urban Indian health care programs, tribal organizations, physicians and other health care professional employees of the Indian Health Service, representatives of the Department of Health and Human Services, as well as physicians and health care professionals employed in the private sector. Testimony received by the Committee strongly supported the need to reauthorize the Indian Health Care Improvementr Act, given the outstanding unmet health care needs of Indians and Alaska Natives that were documented in the hearing process.

On November 18, 1983, Senator Mark Andrews, Chairman of the Senate Select Committee on Indian Affairs, introduced S. 2166, a bill to reauthorize the Indian Health Care Improvement Act of 1976 through Fiscal Year 1988. The Committee held two hearings on the bill in Washington, D.C. on February 29, 1984, and in Denver, Colorado on March 17, 1984. In response to testimony received from national Indian organizations, professional medical associations. Indian tribes, urban Indian health care programs, and Administration respresentatives, the Committee made several changes to the bill as introduced, and an amendment in the nature of a substitute to S. 2166 was unanimously approved by the members of the Select Committee on Indian Affairs in a May 9, 1984 mark-up of the bill to reauthorize the Indian Health Care Improvement Act.

S. 2166 was passed by both Houses of Congress in the 98th Congress, but was vetoed by the President on October 19, 1984, following the sine die adjournment of the 98th Congress. The two primary reasons cited as grounds for the veto referred to a demonstration program in the State of Montana and a Congressionally-appointed commission on the organizational placement of the Indian Health Service within the Department of Health and Human Services. Both provisions have been deleted from the current legislation.

LEGISLATIVE HISTORY

S. 277 was introduced in the Senate on January 24, 1985 by Senator Andrews, for himself, and Senators Abdnor, Baucus, Bingaman, Boschwitz, Burdick, Cochran, DeConcini, Domenici, Durenberger, Evans, Goldwater, Gorton, Hatfield, Inouye, Kennedy, Melcher, Murkowski, Pressler, Sarbanes, Stevens and Zorinsky. S. 277 was referred to the Select Committee on Indian Affairs. The Committee held a hearing on S. 277 on March 6, 1985, and ordered reported an amendment in the nature of a substitute to S. 277 on May 2, 1985. A companion bill, H.R. 1426, was introduced in the House of Representatives on March 5, 1985 by Congressman Udall, for himself and 33 cosponsors. H.R. 1426 was jointly referred to the House Interior and Insular Affairs Committee and the Committee on Energy and Commerce. H.R. 1426 was ordered reported by the Interior and Insular Affairs Committee on April 24, 1985. The House Subcommittee on Health and the Environment of the Energy and Commerce Committee reported H.R. 1426 to the full committee on April 4, 1985. The House Energy and Commerce Committee ordered H.R. 1426 reported on May 15, 1985.

SUMMARY OF MAJOR CHANGES

A new section of Title I (Indian Health Manpower) expresses the intent of the Congress that the Community Health Representative

Program of the Indian Health Service is to be a permanent program of the Indian Health Service, and that the authority for appropriations for the Community Health Representative Program lies in the Snyder Act of 1921. The Secretary of the Department of Health and Human Services is directed to provide paraprofessional training to community health representatives, with emphasis on health promotion and disease prevention activities. Amendments to title I provide for the inclusion of Native Hawaiians in the Health Professions Scholarship Program that is administered by the U.S. Public Health Service, subject to the availability of additional appropriations for that purpose.

Title II (Health Services) authorizes the Indian Health Service to begin a two-year effort of raising all Indian tribes and Alaska Native communities to a Level II of health resources deficiency, which is defined as a 40% to 20% deficiency in unmet health care needs. Following the two-year undertaking, the Indian Health Service is then authorized to commence a three-year effort to raise all Indian tribes and Alaska Native communities to a Level I deficiency, which is defined as a 20% to 0% deficiency in unmet health care needs. Funds appropriated for this purpose are to be designated as the Indian Health Care Improvement Fund, and are to be in addition to amounts appropriated for base Indian Health Service program obligations. Programs administered by Indian tribes or tribal organizations under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act are to be eligible for funds appropriated to the Indian Health Care Improvement Fund on an equal basis with programs that are administered directly by the Indian Health Service. No funds are to be made available to tribes or Alaska Native organizations that are classified as having a Level I deficiency, until all tribes or Alaska Native groups in a Level II classification have been raised to a Level I deficiency. Additional funds are authorized to enable the updating of tribal specific health plans. The tribal specific health plans are to form the basis of the Indian Health Service health services priority system.

The Secretary is directed to report annually to the Congress on the current status of health resources deficiency for each Indian tribe, tribal organization, and Alaska Native community. Rehabilitative care related to alcoholism, treatment and control and rehabilitative care related to drug abuse, home health care, emergency medical services, and community health representatives are added to the health service responsibilities of the Secretary, acting through the Indian Health Service. Title II also authorizes the Indian Health Service to provide health promotion and disease prevention services to eligible Indian people. An Indian Catastrophic Health Emergency Fund is established to relieve the financial burden on the contract health care budget of the Indian Health Service, by making funds available to cover the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses falling within the responsibility of the Indian Health Service.

Title III (Health Facilities) directs the Seretary to submit to the Congress, the planning, design, construction, and renovation needs for the ten top-priority inpatient care facilities and the ten top-priority ambulatory care facilities, as well as the required personnel quarters associated with each facility. Title III adopts the level of deficiency in unmet needs approach to the construction of safe water supply, sanitary sewage and solid waste disposal facilities for existing Indian and Alaska Native homes and communities and for new and renovated Indian and Alaska Native homes. The Secretary is required to develop and begin implementation of a ten-year plan to provide those services, as well as to provide financial and technical assistance to Indian tribes and communities for the management and maintenance of water and sanitation systems. Programs administered by Indian tribes or tribal organizations under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act are to be eligible for Title III programs on an equal basis with programs that are administered directly by the Indian Health Service. Title III directs the Secretary to submit a report to the Congress that indicates the amount of funds necessary to raise all Indian tribes and Alaska Native communities to a Level II deficiency and the amount of funds necessary to raise all Indian tribes and Alaska Native communities to a Level I deficiency.

Title IV (Access to Health Services) expands the kinds of Indian Health Service facilities that are eligible for Medicare and Medicaid reimbursements to include Indian Health Service hospitals, skilled nursing facilities, outpatient facilities, health centers and health stations, as well as facilites that are operated by a tribe or tribal organization under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, and tribally-owned nusing homes, hospitals, and outpatient facilities. Title IV directs the Secretary to return to the service unit responsible for the collection of Medicare and Medicaid funds, at least 50% of the amounts collected by a service unit, provided that such amounts are used exclusively for the purpose of making any imrovement in Indian Health Service facilities that may be necessary to achieve compliance with conditions and requirements of the Medicare and Medicaid programs. Title IV also authorizes a demonstration program for tribes of tribal organizations that are contracting the entire operations of an entire helath care facility, to enable such tribes or tribal organizations to bill directly and retain 100% of the funds collected from Medicaid and Medicare and third-party sources. Title IV also authorizes a study of barriers to Indian participation in the Federal Medicaid and Medicare programs.

Title V (Urban Indian Health Care) expresses the intent of the Congress that the urban Indian health care program is to be a permanent program of the Indian Health Service, and that authority for appropriations to fund the urban Indian health care program lies in the Snyder Act of 1921.

Title VI (Organizational Improvements) establishes the Indian Health Service as an agency of the Public Health Service, and transfers all functions of the Department of Health and Human Services related to the provision of health care to Indian people to the Indian Health Service agency. Title VI also establishes a management information system for the Indian Health Service that is to include a financial management system, a services-based cost accounting system, a patient care information system, and a privacy component to protect the privacy of patient information held by or on behalf of the Indian Health Service. The implementation of the management information system is an important priority in improving the capacity of the Indian Health Service to provide quality health care to Indian and Alaska Native people.

Title VII (Miscellaneous) provides for the establishment of a juvenile alcohol and drug abuse prevention and education program, coordinating the efforts of the Department of Health and Human Services, the Department of Education, and the Department of the Interior. Title VII authorizes the Secretary of the Department of Health and Human Services to enter into appropriate arrangements with the National Academy of Sciences, in consultation with the Office of Technology Assessment, to conduct a study of health hazards to Indian miners and to Indians living on or near Indian reservations or in Indian communities that result from the development of nuclear resources. Title VII amends the definition of eligibility for Indian Health Service services for California Indians in order to conform with current practice. Title VII designates the State of California as a contract health service delivery area excluding certain named counties. Title VII directs the Indian Health Service to provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act for the maintenance and repair of clinics owned or leased by tribes or tribal organizations, for employee training, for cost-of-living increases for employees, and for any other expenses relating to the provision of health services on the same basis as such funds are provided to programs and facilities that are operated directly by the Indian Health Service.

Title VII authorizes the Secretary of the Department of Health and Human Services to remove a member of the National Health Service Corps from a health facility operated by a tribe or tribal organization under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act only if the Secretary has provided written notice of the removal or withdrawal to the tribe or tribal organization at least 60 days before the date on which a contract is entered into or renewed, and the Secretary provides funds or other personnel as may be necessary to ensure that the Indians who receive services from the National Health Service Corps members will not experience a reduction in services. Title VII also authorizes the Secretary of the Department of Health and Human Services to provide or authorize the provision of medical care, treatment, or benefits by the Indian Health Service to persons who are not otherwise eligible for such services in health facilities maintained by the Indian Health Service, in facilities contracted under the Indian Self-Determination and Education Assistance Act, or through contract health care services, subject to certain limitations. Title VII authorizes a program for the prevention and control of Hepatitis B in the State of Alaska.

Title VII directs the Secretary of the Department of Health and Human Services to reduce the incidence of infant mortality, maternal mortality, and fetal alcohol syndrome in the Indian population to the level accepted for the United States population generally by 1991. Title VII also authorizes the Secretary of the Department of Health and Human Services to enter into an arrangement for the sharing of resources between the Indian Health Service and the Veterans' Administration. Title VII designates three counties in the State of North Dakota and three counties in the State of Montana that currently comprise the Trenton Service Area as a contract health service delivery area for the provision of contract care to members of the Turtle Mountain Band of Chippewa Indians. Title VII authorizes the Secretary of the Department of Health and Human Services to conduct a study of the health care needs of Native Hawaiians and other Native American Pacific Islanders. Title VII also authorizes the Secretary of the Department of Health and Human Services to establish a health promotion and disease prevention demonstration program in conjunction with the University of Hawaii School of Medicine to serve Native Hawaiians. The focus of the program is to emphasize maternal and child health care, prevention of alcoholism, and prevention of child abuse, as well as general health promotion and disease prevention activities.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

The Select Committee on Indian Affairs, in open business session on May 2, 1985, by unanimous vote and with a quorum present, recommends that the Senate pass S. 277.

SECTION-BY-SECTION ANALYSIS

Section 1 provides that S. 277 is to be referred to as the Indian Health Care Amendments of 1985.

Section 2 states that whenever a reference to an amendment or repeal of a section or provision is cited in S. 277, the reference is to be considered to be made to a section or provision of the Indian Health Care Improvement Act.

Title I—Indian Health Manpower

Section 101 amends section 102 of the Act to extend authority for the health professions recruitment program for Indians, and authorizes appropriations in the amount of $600,000 for fiscal year 1986; $650,000 for fiscal year 1987; $700,000 for fiscal year 1988; and $750,000 for fiscal year 1989.

Section 102 amends section 103 of the Act to extend authority for the health professions preparatory scholarship program and provides that the Secretary of the Department of Health and Human Services is not to deny scholarship assistance to an applicant who is otherwise eligible for a health professions preparatory scholarship solely on the basis of the applicant's scholastic achievement if the applicant has been admitted to an accredited institution or if the applicant has maintained good standing at an accredited institution. Good standing at an accredited institution is a determination made by the relevant institution. Section 102 also authorizes appropriations in the amount of $4,700,000 for fiscal year 1986; $5,400,000 for fiscal year 1987; $6,100,000 for fiscal year 1988; and $6,800,000 for fiscal year 1989 for the health professions preparatory scholarship program. Section 102 further amends section 103(c) of the Act to make clear that scholarship grants may cover costs of tuition, books, transportation, board and other necessary related expenses of a grantee only while the grantee is attending school full time.

Section 103 amends section 105 of the Act to authorize appropriations in the amount of $350,000 for fiscal year 1986; $400,000 for fiscal year 1987; $450,000 for fiscal year 1988; and $500,000 for fiscal year 1989 for the Indian Health Service extern program.

Section 104 amends section 338G of the Public Health Service Act to change the reference to section numbers and to authorize appropriations in the amount of $7,000,000 for fiscal year 1986; $8,100,000 for fiscal year 1987; $9,234,000 for fiscal year 1988; and $10,300,000 for fiscal year 1989 for the health professions scholarship program. Section 104 also amends section 338G of the Public Health Service Act to make Native Hawaiians eligible for scholarship assistance from the health professions scholarship program, subject to the availability of additional appropriations for that purpose. Indians would still be accorded preference in the award of scholarships. Section 104 further amends section 338G of the Public Health Service Act to provide that in addition to serving in the Indian Health Service, or in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of the applicable profession, a health professions scholarship recipient may fulfill the active duty service obligation by service in a program conducted under a contract entered into under the Indian Self-Determination and Education Assistance Act. The amendments made by section 104 to section 338G of the Public Health Service Act also provide that the Secretary of the Department of Health and Human Services is not to deny scholarship assistance to any eligible health professions scholarship applicant solely upon the basis of the applicant's scholastic achievement if the applicant has been admitted to an accredited educational institution to pursue a course of study described in subsection (a) of section 338G of the Public Health Service Act.

Section 104 amendments to section 338G of the Public Health Service Act further provide that the active duty service obligation of a Native Hawaiian health professions scholarship recipient is to be fulfilled by service in the Indian Health Service, in a program conducted under a contract entered into under the Indian Self-Determination and Education Assistance Act; in a program assisted under title V of the Indian Health Care Improvement Act; or in the private practice of the applicable profession if, as determined by the Secretary of the Department of Health and Human Services, in accordance with guidelines promulgated by the Secretary, the private practice is situated in a physician or other health professional shortage area and the practice addresses the health care needs of a substantial number of Indians or Native Hawaiians. Section 104 also amends section 338G of the Public Health Service Act to define the term "Indian" to conform to the meaning given the term "Indian" by section 4(c) of the Indian Health Care Improvement Act and to include the individuals described in clauses (1) through (4) of sectin 4(c) of the Indian Health Care Improvement Act. Section 104 additionally amends section 338G of the Public

Health Service Act to define the term "Native Hawaiian" to mean any individual who has any ancestors that were natives, prior to 1778, of the area which now comprises the State of Hawaii.

Section 105 amends Title I to add a new section 107 which authorizes the Secretary of the Department of Health and Human Services, under the authority of the Snyder Act of 1921 (25 U.S.C. 13), to maintain a community health representative program. In maintaining the community health representative program, the Indian Health Service is to provide for the training of Indians as health paraprofessionals and is to use community health representatives, as paraprofessionals, in the provision of health care to Indian communities. Section 107 authorizes the Secretary of the Department of Health and Human Services, acting through the community health representative program of the Indian Health Service, to provide a high standard of paraprofessional training to community health representatives to ensure that community health representatives are able to provide quality health care to the Indian communities served by the community health representative program. In order to provide the paraprofessional training, section 107 authorizes the Secretary of the Department of Health and Human Services to develop a curriculum that combines education in the theory of health care with supervised practical experience in the provision of health care; that provides instruction and practical experience in health promotion and disease prevention activities, particularly in the areas of nutrition, physical fitness, weight control, cessation of tobacco smoking, stress management, control of alcohol and drug abuse including prevention of fetal alcohol syndrome, control of high blood pressure, prevention of lifestyle related accidents, prevention and management of hearing and vision problems, and prevention of diabetes; and that provides instruction in the latest and most effective social, education, and behavioral approaches to the establishment and maintenance of good health habits.

Section 107 also authorizes the Secretary of the Department of Health and Human Service to develop a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and to develop programs that meet the continuing education needs that have been identified by the system. The Secretary is further authorized to develop and maintain a system that provides for the close supervision of community health representatives and to develop a system under which the work of community health representatives is reviewed and evaluated. The Secretary is also authorized to ensure that the provision of health care, health promotion, and disease prevention activities are consistent with the traditional health care practices and cultural values of the Indian tribes served by the community health representative program.

Title II—Health Services

Section 201 amends section 201 of the Indian Health Care Improvement Act to authorize the Secretary of the Department of Health and Human Services to expend funds that are appropriated under the authority of subsection (j) of section 201, through the Indian Health Service, for the purposes of: raising the health status of Indians to a zero level of deficiency; eliminating backlogs in the provision of health services to Indians; meeting the health needs of Indians in an efficient and equitable manner; and augmenting the ability of the Indian Health Service to meet the health service responsibilities of: direct and indirect clinical care, including clinical eye and vision care; preventive health; direct and indirect dental care; mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners; emergency medical services; treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians; home health care; community health representatives; and maintenance and repair. Section 201 provides that any funds appropriated under the authority of section 201(j) are not to be used to offset or limit any appropriations made to the Indian Health Service under the authority of the Snyder Act of 1921 (25 U.S.C. 13) or any other provision of law.

Section 201 further provides that funds that are appropriated under the authority of section 201(j) may be allocated to or used for the benefit of any Indian tribe which has a health resources deficiency level at Level I or II, only if a sufficient amount of funds have been appropriated under the authority of section 201(j) to raise all other Indian tribes to a Level II of health resources deficiency. Section 201 also provides that funds appropriated under the authority of section 201(j) may be allocated on a service unit basis, but with the proviso that such funds must be used by each service unit in accordance with the requirements of section 201(b)(2) to raise the deficiency level of each tribe served by the service unit. Section 201 provides that the apportionment of funds allocated to a service unit under section 201(b)(3)(A) among the health service responsibilities described in section 201(a)(4) are to be determined by the Indian Health Service and the affected Indian tribes. Section 201 defines the health resources deficiency levels of Indian tribes and provides that Level I means a zero to twenty percent deficiency, Level II means a twenty-one to forty percent deficiency, Level III means a forty-one to sixty percent deficiency, Level IV means a sixty-one to eighty percent deficiency, and Level V means an eighty-one to one hundred percent deficiency. Section 201 authorizes the Secretary of the Department of Health and Human Services to establish procedures under regulations which will allow any Indian tribe to petition the Secretary for a review of any determination of the health resources deficiency level of that tribe. Section 201 provides that programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act are to be eligible for funds appropriated under the authority of section 201(j) on an equal basis with programs that are administered directly by the Indian Health Service.

Section 201 provides that if any funds allocated to a tribe or service unit under the authority of section 201 are used for a contract entered into under the Indian Self-Determination and Education Assistance Act, a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions. A reasonable portion means any percentage of such funds that does not exceed the negotiated indirect cost rate of the relevant tribe. Section 201 authorizes the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to expend directly or by contract, including contracts entered into under the authority of the Indian Self-Determination and Education Assistance Act, not less than one percent of the funds appropriated under the authority of section 201(j) for research in the areas of Indian Health Service health service responsibilities set forth in section 201(a)(4)(A) through (H). Section 201 requires the Secretary of the Department of Health and Human Services to submit to the Congress by no later than the date that is sixty days after the date of enactment of the Indian Health Care Amendments of 1985, the current health services priority system report of the Indian Health Service for each Indian tribe or service unit, including newly recognized or acknowledged tribes. The report required by section 201 is to set out: the methodology for determining tribal health resources deficiencies; the level of health resources deficiency for each Indian tribe; the amount of funds necessary to raise all Indian tribes below a Level II of health resources deficiency to a Level II of health resources deficiency; the amount of funds necessary to raise all tribes below a Level I of health resources deficiency to a Level I of health resources deficiency; the amount of funds necessary to raise all tribes to a zero level of health resources deficiency; as well as an estimate of the amount of health service funds appropriated under the authority of the Indian Health Care Improvement Act or any other Act for the preceding fiscal year that has been allocated to each service unit, Indian tribe, or comparable entity; and the number of Indians eligible for health services in each service unit or Indian tribe.

Section 201 requires the Secretary of the Department of Health and Human Services, acting through the Indian Health Service and in conjunction with each Indian tribe, to annually update the tribal specific health plans that were developed as part of the plan required under section 703 of the Indian Health Care Improvement Act. The updating of the tribal specific health plans is to be carried out in accordance with the methodology submitted to the Congress as part of the current health services priority system report of the Indian Health Service, as modified through consultation with the Indian tribe to which the tribal specific health plan relates. Section 201 also requires the Secretary to submit to the Congress an annual report on the health services priority system of the Indian Health Service by no later than sixty days after the date that the President submits to the Congress the budget required under the authority of section 1105 of title 31 of the United States Code for any fiscal year beginning after September 30, 1986. The report is to be based on the updated tribal specific health plans. Section 201 directs the President to include with the budget submitted under section 1105 of title 31 of the United States Code, for each fiscal year, a separate statement that specifies the amount of funds requested by the President to carry out the provisions of section 201 for the relevant fiscal year, and that specifies the total amount obligated or expended in the most recently completed fiscal year to carry out section 201(g) and the total amount obligated or expended in the most recently completed fiscal year to carry out each of the subparagraphs of section 201(a)(4). Section 201 provides that funds appropriated under the authority of section 201 for any fiscal year are to be included in the base budget of the Indian Health Service for the purpose of determining appropriations under the authority of section 201 in subsequent fiscal years. Section 201 further provides that nothing in section 201 is intended to diminish the primary responsibility of the Indian Health Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of section 201 intended to discourage the Indian Health Service from undertaking additional efforts to achieve parity among Indian tribes. It is the intention of the Committee to encourage the Indian Health Service to undertake additional efforts to achieve parity among Indian tribes and Indian Health Service service units.

Section 201(j) authorizes appropriations for the purpose of carrying out the provisions of section 201 in the amount of $29,000,000 for fiscal year 1986; $28,000,000 for fiscal year 1987; $46,000,000 for fiscal year 1988; and $46,000,000 for fiscal year 1989. Section 201 provides that any funds appropriated under the authority of section 201(j) are to be designated as the Indian Health Care Improvement Fund. Section 201 also amends section 4 of the Indian Health Care Improvement Act by striking out subsections (i), (j), and (k), and by inserting in lieu thereof, new subsections (i) and (j) to provide definitions of what is meant by the terms "area office" means an administrative entity including an Indian Health Service program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area. Section 201 provides that the term "service unit" means an administrative entity within the Indian Health Service, or a tribe or tribal organization operating health care programs or facilities with funds from the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

Section 202 amends Title II of the Act to add a new sectaion 202 to the Indian Health Care Improvement Act establishing an Indian Catastrophic Health Emergency Fund. The Fund is to consist of the amounts deposited to the Fund under the authority of section 202(d), and the amounts appropriated under the authority of section 202(e). The Fund is to be administered by the Secretary of the Department of Health and Human Services, acting through the central office of the Indian Health Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses falling within the responsibility of the Indian Health Service. The Fund is not to be allocated, apportioned, or delegated on a service unit, area office, or any other basis. No part of the Fund or its administration is to be subject to a contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

Section 202 requires the Secretary of the Department of Health and Human Services, through the promulgation of regulations consistent with the provisions of section 202, to establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the

Fund; and to provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until the service unit's cost of treating any victim of a catastrophic illness or disaster has reached a certain threshold cost.

The Secretary is to establish the threshold cost at not less than $10,000 and not more than $20,000. The Secretary is further directed to establish a procedure for the reimbursement of the portion of the costs incurred by service units or Indian Health Service facilities; and to establish a procedure for the reimbursement of the portion of costs incurred by non-Indian Health Service facilities or providers in rendering treatment that exceeds the threshold cost whenever such treatment is otherwise authorized by the Indian Health Service. The Secretary is directed to establish a procedure for payment from the Fund in cases where the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Indian Health Service. The Secretary is also directed to establish a procedure that will assure that no payment is to be made from the Fund to any provider of treatment, to the extent that the provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient receiving such treatment is eligible. Section 202 requires that funds appropriated under the authority of section 202(e) are not to be used to offset or limit appropriations made to the Indian Health Service under the authority of the Snyder Act of 1921 (25 U.S.C. 13) or any other law.

Section 202 authorizes the deposit into the Fund of all reimbursements to which the Indian Health Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness falling within the responsibility of the Indian Health Service. Section 202 also authorizes the deposit into the Fund of all funds recovered under the authority of the Federal Medical Care Recovery Act (42 U.S.C. 2641 et. seq.) by reason of treatment rendered to any victim of a disaster or catastrophic illness falling within the responsibility of the Indian Health Service. Section 202 authorizes appropriations in the amount of $12,000,000 for fiscal year 1986, and such sums as may be necessary to restore the Fund to a level of $12,000,000 for fiscal years 1987, 1988, and 1989, for the purpose of carrying out the provisions of section 202. Funds appropriated under section 202(e) are to remain available until expended. It is the intent of the Committee that the Secretary shall expend any amounts from the Fund in any fiscal year for the purposes authorized, and that within any fiscal year, the Secretary is not to maintain the fund at $12,000,000 level following such expenditures. The Committee intends that any depletion in the Fund associated with such expenditures will be addressed by the appropriations actions of the Congress in the succeeding fiscal year, so that at the beginning of each fiscal year, the Fund can be restored to the $12,000,000 level.

Section 203 sets forth Congressional findings that health promotion and disease prevention activities will improve the health and well being of Indians and will reduce the expenses for medical care of Indians; that health promotion and disease prevention activities should be undertaken by the coordinated efforts of Federal, State, local, and tribal governments; and that in addition to the provision of primary health care, the Indian Health Service should provide health promotion and disease prevention services to Indians. Section 203 amends section 4 of the Indian Health Care Improvement Act, as further amended by section 201(b) of S. 277, to add new subsections (k) and (l) which define the meaning given the terms "health promotion" and "disease prevention". The amendments made to section 4 of the Act by section 203 provide that the term "health promotion" includes cessation of tobacco smoking, reduction in the misuse of alcohol and drugs, improvement of nutrition, improvement physical fitness, family planning, and control of stress. The term "disease prevention" includes immunizations, control of high blood pressure, control of sexually transmittable diseases, prevention and control of diabetes, pregnancy and infant care (including prevention of fetal alcohol syndrome), control of toxic agents, occupational safety and health, accident prevention, fluoridation of water, and control of infectious agents. Section 203 also amends Title II of the Indian Health Care Improvment Act to add a new section 203 that authorizies the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to provide health promotion and disease prevention services to Indians. Section 203 requires the Secretary to include within the health services priority system report required under section 201(g), an evaluation of the health promotion and disease prevention needs of Indians identified in tribal specific health plans, the health promotion and disease prevention activities which would best meet the needs identified, the resources that would be required to enable the Indian Health Service to undertake the health promotion and disease prevention activities necessary to meet the identified needs, and the resources currently available to the Indian Health Service which could be used to undertake health promotion and disease prevention activities.

Title III—Health Facilities

Section 301 amends section 301 of the Indian Health Care Improvement Act to require the Secretary of the Department of Health and Human Services, prior to the expenditure or the making of any firm commitment to expend any funds appropriated for the planning, design, construction, or renovation of facilities under the authority of the Snyder Act of 1921 (25 U.S.C. 13), to act through the Indian Health Service to consult with any Indian tribe that would be significantly affected by the expenditure for the purpose of determining and whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which the expenditure is to be made, and to ensure, whenever practicable, that the facility meets the standards of the Joint Commission on Accreditation of Hospitals by no later than one year after the date on which the construction or renovation of a facility is completed. Section 301 directs that nowwithstanding any other provision of law, no Indian Health Service hospital or other outpatient health care facility of the Indian Health Service or any portion of an Indian Health Service hospital or facility may be closed if the Secretary of the Department of Health and Human Services has not submitted to the Congress, at least one year prior to the date a hospital, facility, or portion of a hospital or facility is proposed to be closed, an evaluation of the impact of the proposed closure that specifies in addition to other considerations: the accessibility of alternative health care resources for the population served by the hospital or facility; the cost effectiveness of the closure; the quality of health care to be provided to the population served by the hospital or facility after the proposed closure; the availability of contract health care funds to maintain existing levels of service; and the views of the Indian tribes served by the hospital or facility concerning the proposed closure.

Section 301 authorizes the Secretary to close a facility or any portion of a facility on a temporary basis if the closure is necessary for medical, environmental, or safety reasons. Section 301 directs the President to include with the budget submitted under section 1105 of title 31 of the United States Code for each of the fiscal years 1987, 1988, and 1989, program information documents for the construction of ten Indian health facilities that comply with applicable construction standards and have been approved by the Secretary of the Department of Health and Human Services.

Section 301 also requires the Secretary of the Department of Health and Human Services to submit an annual report to the Congress that sets forth: the current health facility priority system of the Indian Health Service, the planning, design, construction, and renovation needs for the ten top-priority inpatient care facilities and the ten top-priority ambulatory care facilities (together with the number of personnel quarters required for each facility); the justification for the order of the priority; the projected cost of each project; and the methodology adopted by the Indian Health Service in establishing priorites under the Indian Health Service facility priority system. The first such report is to be submitted no later than the date that is 180 days after the date of enactment of the Indian Health Care Amendments of 1985, and beginning in 1986, each subsequent annual report is required to be submitted by the date that is 60 days after the date on which the President submits the budget to the Congress under section 1105 of title 31 of the United States Code. Other than the initial report, in preparing each subsequent report, the Secretary is directed to consult with Indian tribes and tribal organizations including tribes or tribal organizations that operate health programs or facilities under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, and review the needs of such tribes and tribal organizations for inpatient and outpatient health facilities, including their needs for renovation and expansion of existing facilities.

In evaluating the needs of facilities operated under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, the Secretary is required to use the same criteria that the Secretary uses in evaluating the needs of facilities that are operated directly by the Indian Health Service. Section 301 directs the Secretary to ensure that the planning, design, construction, and renovation needs of the Indian Health Service and non-Indian Health Service facilities that are operated under contract with the Indian Health Service under the authority if the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the development of the health facility priority system. The Committee intends that facilities that are operated under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act are to be integrated into the health facility priority system on the same basis that directly-operated Indian Health Service facilities are integrated into the health facility priority system.

Section 302 amends section 302 of the Indian Health Care Improvement Act to set forth Congressional findings that: the provision of safe water supply systems and sanitary sewage and solid waste disposal systems is primarily a health consideration and function; Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such systems; the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such systems and other preventive health measures; many Indian homes and communities still lack safe water supply systems and sanitary sewage and solid waste disposal systems; and it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible.

In furtherance of the Congressional findings and declarations set forth in section 302, Congress reaffirms the primary responsibility and authority of the Indian Health Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Section 302 authorizes the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to provide under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a): financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities; ongoing technical assistance and training in the management of utility organizations that operate and maintain sanitation facilities; and operation and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities in situations in which the community, tribe, or family is not financially or technically capable of operating or maintaining the system, or of performing required emergency repairs, with their own resources. Beginning in fiscal year 1986, section 302 requires the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to develop and begin implementation of a ten-year plan to provide safe water supply and sanitation sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

Section 302 provides that the financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility is not to be a prerequisite to the provision or construction of sanitation facilities by the Secretary of the Department of Health and Human Services. Section 302 further provides that the provisions of section 302 are not to be construed as diminishing the primary responsibility of an Indian family, community, or tribe to establish, collect, and utilize reasonable user fees, or otherwise, set aside funding for the purpose of operating and maintaining sanitation facilities. Section 302 also provides that programs administered by Indian tribes or tribal organizations under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act are to be eligible for any funds appropriated under the authority of section 302(h) and any funds appropriated for the purpose of providing water supply or sewage disposal services, on an equal basis with programs that are administered directly by the Indian Health Service. Section 302 directs the Secretary of the Department of Health and Human Services to submit an annual report to the Congress that sets forth: the current Indian sanitation facility priority system of the Indian Health Service; the methodology for determining sanitation deficiencies; the level of sanitation deficiency for each Indian tribe or community; the amount of funds necessary to raise all Indian tribes and communities to a Level I of sanitation deficiency; and the amount of funds necessary to raise all Indian tribes and communities to a zero level of sanitation deficiency. Section 302 requires that the first report to be submitted to the Congress by the Secretary is to be submitted by no later than the date that is one hundred and eighty days after the date of enactment of the Indian Health Care Amendments of 1985.

Beginning in fiscal year 1986, section 302 requires that each subsequent annual report is to be submitted by the date that is sixty days after the date on which the President submits the budget to the Congress under section 1105 of title 31 of the United States Code. Other than the initial report, the Secretary is required in preparing each subsequent report to consult with Indian tribes and tribal organizations, including tribes and tribal organizations operating health care programs or facilities under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, to determine the sanitation needs of each tribe. Section 302 requires that the methodolgy used by the Secretary in determining sanitation deficiencies is to be applied uniformly to all Indian tribes and communities. Section 302 defines the sanitation deficiency levels for Indian tribes and communities. Level I means an Indian tribe or community with a sanitation system that complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to routine replacement, repair, or maintenance needs. Level II means an Indian tribe or community with a sanitation system that complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to capital improvements that are necessary to improve the facilities in order to meet the needs of the tribe or community for domestic sanitation facilities. Level III means an Indian tribe or community with a sanitation system that has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or has no solid waste disposal facility. Level IV means an Indian tribe or community with a sanitation system that lacks either safe water supply system or a sewage disposal system.

Level V means an Indian tribe or community that lacks a safe water supply and a sewage disposal system.

Section 302 provides that for purposes of these definitions, any Indian tribe or community that lacks the operation and maintenance capability to enable its sanitation system to meet pollution control laws may not be treated as having a Level I or Level II sanitation deficiency. Section 302 authorizes appropriations in the amount of $5,000,000 for fiscal year 1986; $5,000,000 for fiscal year 1987; $5,000,000 for fiscal year 1988; and $5,000,000 for fiscal year 1989 for the purpose of providing funds necessary to implement the responsibilities of the Indian Health Service described in section 302(b)(2). Section 302 also authorizes appropriations in the amount of $850,000 for fiscal year 1986; $850,000 for fiscal year 1987; $850,000 for fiscal year 1988; and $850,000 for fiscal year 1989 for the purpose of providing thirty new full-time equivalent positions for the Indian Health Service which are to be used to carry out the responsibilities of the Indian Health Service described in section 302(b)(2).

Section 303 amends section 305 of the Indian Health Care Improvement Act to provide that notwithstanding any other provision of law, the Secretary of the Department of Health and Human Services is authorized to accept any major renovation or modernization by any Indian tribe of any Indian Health Service facility, or of any other Indian health facility operated under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, including any plans or designs for such renovation or modernization and any renovation or modernization for which funds appropriated under any Federal law were lawfully expended, with the proviso that the requirements of section 305(b) must be met. Section 305(b) provides that the requirements of section 305(b) will be met with respect to any renovation or modernization if the renovation or modernization does not require or obligate the Secretary to provide any additional employees or equipment, is approved by the appropriate area director of the Indian Health Service, and is administered by an Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Indian Health Service facilities. A renovation or modernization is not to be authorized by section 305 is the renovation or modernization would require the diversion of funds appropriated to the Indian Health Service from any project that has a higher priority under the Indian Health Service health facility priority system. Section 305 further provides that if any Indian Health Service facility that has been renovated or modernized by an Indian tribe under the authority of section 305 ceases to be used as an Indian Health Service facility during the twenty-year period beginning on the date the renovation or modernization is completed, the Indian tribe will be entitled to recover from the United States an amount which bears the same ratio to the value of the facility at the time of the cessation of its use as a health facility, as the value of the renovation or modernization bore to the value of the facility at the time of completion of the renovation or modernization, less the total amount of funds provided specifically for the facility under any Federal program that was expended for the renovation or modernization. Section 305 also deletes duplicative language in Public Law 98-473, the law which authorizes appropriations for fiscal year 1985.

Title IV—Access to Health Services

Section 401 amends section 404 of the Indian Health Care Improvement Act to provide that grants or contracts entered into by the Secretary of the Department of Health and Human Services with tribal organizations may be used to assist individual Indians to: enroll under section 1818 of part A and sections 1836 and 1837 of part B of title XVIII of the Social Security Act; to pay monthly premiums for coverage due to financial need of individual Indians; or to apply for medical assistance provided under the authority of title XIX of the Social Security Act. Section 401 also amends section 404(b) of the Act to authorize the Secretary of the Department of Health and Human Services to place conditions as deemed necessary to effect the purpose of section 404 and that such conditions may include, as appropriate, requirements that the organization successfully undertake to: determine the population of Indians to be served that are or could be recipients of benefits under titles XVIII and XIX of the Social Security Act; assist individual Indians in becoming familiar with and utilizing such benefits; provide transportation to such individual Indians to the appropriate offices for enrollment or application for medical assistance; and develop and implement a schedule of income levels to determine the extent of payment of premiums by such organization for coverage of needy individuals, and methods of improving participation of Indians in receiving benefits provided pursuant to titles XVIII and XIX of the Social Security Act. Section 401 further amends section 404 of the Act to authorize appropriations in the amount of $1,500,000 for fiscal year 1986; $2,000,000 for fiscal year 1987; $500,000 for fiscal year 1988; and $500,000 for fiscal year 1989 for the purpose of making grants or contracts with tribal organizations to carry out the provisions of section 404.

Section 402 amends section 1880 of the Social Security Act by expanding the kinds of Indian Health Service facilities that are eligible for reimbursements from the Federal Medicare program on the basis of services rendered by the Indian Health Service to Medicare-eligible Indian patients. The terms "providers of services or a rural health clinic" is intended to include Indian Health Service hospitals, skilled nursing facilities, outpatient facilities, health centers and health stations, as well as facilities that are operated by a tribe or tribal organization under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, and tribally-owned nursing homes, hospitals, and outpatient facilities. Section 402 further amends section 1880(c) of the Social Security Act to direct that the Secretary of the Department of Health and Human Services is to return to the service unit responsible for the collection of Medicare reimbursements, at least fifty percent of the amounts collected by the service unit, provided that such amounts are used exclusively for the purpose of making any improvements in Indian Health Service facilities which may be necessary to achieve compliance with conditions and requirements of the Medicare program. Section 402 requires the Secretary to make the return payments to each service unit from the special fund that is established exclusively for the purpose of making any improvements in Indian Health Service facilities that may be necessary to achieve compliance with conditions and requirements of the Medicare program. Section 402 provides that the amendments made by section 402 are to apply to service performed on or after the date of enactment of the Indian Health Care Amendments of 1985.

Section 403 amends section 1911 of the Social Security Act by expanding the kinds of Indian Health Service facilities that are eligible for reimbursements from the Federal Medicaid program on the basis of services rendered by the Indian Health Service to Medicaid-eligible patients. The terms "skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan" is intended to include Indian Health Service hospitals, skilled nursing facilities, outpatient facilities, health centers, and health stations, as well as facilities that are operated by a tribe or tribal organization under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, and tribally-owned nursing homes, hospitals, and outpatient facilities. Section 403 further amends section 1911 of the Social Security Act to authorize the Secretary of the Department of Health and Human Service to enter into agreements with a State agency for the purpose of reimbursing that agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

Section 403 also amends section 1911 of the Social Security Act to direct the Secretary of the Department of Health and Human Services to establish a special fund, to be held by the Secretary and used by the Secretary, to such extent or in such amounts as are provided in appropriation acts of Congress, exclusively for the purpose of making any improvements in the facilities of the Indian Health Service which may be necessary to achieve compliance with the applicable conditions and requirements of title XIX of the Social Security Act. The Secretary is directed to return to the service unit responsible for the collection of Medicaid reimbursements, at least fifty percent of the amounts collected by the service unit, provided that such amounts are used exclusively for the purpose of making any improvements in Indian Health Service facilities which may be necessary to achieve compliance with the conditions and requirements of title XIX of the Social Security Act. The Secretarial requirements authorized by the section 403 amendments to section 1911 of the Social Security Act are to cease to apply when the Secretary determines and certifies that substantially all of the health facilities of the Indian Health Service in the United States are in compliance with the conditions and requirements of title XIX of the Social Security Act. Section 403 also amends section 402 of the Indian Health Care Improvement Act to repeal section 402(b) and 402(c). The amendments made by section 403 are to apply to services performed on or after the date of enactment of the Indian Health Care Amendments of 1985.

Section 404 amends title IV of the Indian Health Care Improvement Act to add a new section 405. Section 405 authorizes the Secretary of the Department of Health and Human Services to establish a demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations, that are contracting the entire operation of an entire hospital or clinic of the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, are authorized to directly bill for and receive payment for health care services provided by the hospital or clinic for which payment is made under title XVIII of the Social Security Act (the Federal Medicare program), under a State plan for medical assistance approved under title XIX of the Social Security Act (the Federal Medicaid program), or from any other third-party payor. It is intended that bills generated by demonstration program participants may include a portion of the cost incurred by such participants for equipment and facilities as part of the rate structure, consistent with the financial management practices and billing procedures that are employed by private sector health care facilities. The Federal medical assistance percentage under the Federal Medicaid program is to continue to be one hundred percent for purposes of the demonstration program.

Section 405 provides that each hospital or clinic participating in the demonstration program is to be reimbursed directly under the Medicare and Medicaid programs for services rendered, without regard to the provisions of sections 1880(c) and 1911(d) of the Social Security Act, but that all funds so reimbursed are first to be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic which may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of the same type under the Medicare and Medicaid programs. Any funds reimbursed from the Medicare and Medicaid programs that are in excess of the amount that is necessary to achieve or maintain the conditions or requirements referred to above are to be used solely for improving the health resources deficiency level of the Indian tribe and in accordance with Indian Health Service regulations applicable to funds provided by the Indian Health Service under any contract entered into under the authority of the Indian Self-Determination and Education Assistance Act. Section 405 provides that amounts paid to the hospitals and clinics participating in the demonstration program are to be subject to all auditing requirements applicable to programs administered directly by the Indian Health Service and to facilities participating in the Medicare and Medicaid programs. Section 405 directs the Secretary of the Department of Health and Human Services to monitor the performance of hospitals and clinics participating in the demonstration program and to require the participating hospitals and clinics to submit reports on the demonstration program on a quarterly basis, or on a more frequent basis if the Secretary deems more frequent reports to be necessary.

Section 405 further provides that no payment is to be made out of the special fund described in sections 1880(c) or 1911(d) of the Social Security Act for the benefit of any hospital clinic that is participating in the demonstration program, notwithstanding sections 1880(c) and 1911(d) of the Social Security Act. The proscription on payments from the special fund is to assure that participating hospitals and clinics do not receive more than one reimbursement for services rendered to Medicare- or Medicaid-eligible patients from

Medicare or Medicaid sources. Section 405 provides that in order to be considered for participation in the demonstration program, a hospital or clinic must submit an application to the Secretary of the Department of Health and Human Services which establishes to the satisfaction of the Secretary that: the Indian tribe or Alaska Native health organization contracts the entire operation of an Indian Health Service facility; the facility is eligible to participate in the Medicare and Medicaid programs under sections 1880 and 1911 of the Social Security Act; the facility meets any requirements that apply to programs operated directly by the Indian Health Service; and the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan which has been approved by the Secretary for achieving such accreditation prior to October 1, 1987. Section 405 directs the Secretary to select no more than four facilities to participate in the demonstration program from among the qualified applicants prior to October 1, 1986. The demonstration program is to begin by no later than October 1, 1987 and end on September 30, 1992. Section 405 further provides that upon enactment of the Indian Health Care Amendments of 1985, the Secretary of the Department of Health and Human Services acting through the Indian Health Service, is to commence an examination of any administrative changes that may be necessary to allow direct billing and reimbursement under the demonstration program, including any agreements with States which may be necessary to provide for direct billing under the Medicaid program; and any changes that may be necessary to enable demonstration program participants to provide medical records information on patients served under the demonstration program to the Indian Health Service that is consistent with the medical records information system of the Indian Health Service.

Prior to the commencement of the demonstration program, the Secretary is directed to implement all changes that may be required as a result of the examination of changes conducted by the Secretary. Prior to October 1, 1986, the Secretary is directed to determine any accounting information that a demonstration program participation would be required to report and to provide funding for the development of any accounting system by any facility that has been selected to participate in the demonstration program, if there is not existing accounting system in that facility. At the end of fiscal year 1992, the Secretary is directed to submit a final report on the activities carried out under the demonstration program and is to include an evaluation of whether such activities have fulfilled the objectives of the program. In the final report, the Secretary is to provide a recommendation based upon the results of the demonstration program, as to whether direct billing of and reimbursement by the Medicare and Medicaid programs and other third-party payors should be authorized for all Indian tribes and Alaska native health organizations that are contracting the entire operation of an Indian Health Service facility. Section 405 further directs the Secretary to provide for the retrocession of any contract entered into between a demonstration program participant and the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority is to be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.

Section 406 directs the Secretary of the Department of Health and Human Services, in consultation with Indian tribes and tribal organizations, to conduct a study of any barriers that may exist to the participation of Indians in programs established under title XVIII of the Social Security Act (the Federal Medicare program) or under title XIX of the Social Security Act (the Federal Medicaid program). The Secretary is directed to submit a report to the Congress on the study conducted by the Secretary by no later than the date which is one year after the date of enactment of the Indian Health Care Amendments of 1985. The report is to include recommendations for legislation that would remove any barriers to participation identified in the Secretary's study and which would encourage participation by Indians in the Medicare and Medicaid programs. The report is also to include estimates by service unit of the potential number of Indians eligible for Medicare, the potential number of Indians eligible for Medicaid, the number of Indians participating in the Medicare program, and the number of Indians participating in the Medicaid programs.

Title V—Urban Indian Health Services

Section 501 declares that the purpose of title V is to encourage the establishment of programs in urban centers to make health services more accessible to urban Indians.

Section 502 directs the Secretary of the Department of Health and Human Services acting through the Indian Health Service to enter into contracts with urban Indian organizations under the authority of the Snyder Act of 1921 (25 U.S.C. 13) to assist those organizations in the establishment and administration of programs that meet the requirements of title V within the urban centers in which such organizations are situated. The Secretary, acting through the Indian Health Service, is to include conditions that the Secretary considers necessary to effect the purpose of title V in any contract which the Secretary enters into with any urban Indian Organization under the provisions of title V.

Section 503 directs the Secretary of the Department of Health and Human Services acting through the Indian Health Service to enter into contracts with urban Indian organizations under the authority of the Snyder Act of 1921 (25 U.S.C. 13) for the provision of health care or referral services for urban Indians residing in the urban centers in which the urban Indian organizations are situated. Any contract entered into by the Secretary with an urban Indian organization is to include requirements that the urban Indian organization successfully undertake to: determine the population of urban Indians residing in the urban center in which the urban Indian organization is situated who are or could be recipients of health care or referral services; determine the current health status of urban Indians residing in the urban center; determine the current health care needs of urban Indians residing in the urban center; identify all public and private health services resources within the urban center which are or may be available to urban Indians; determine the use of public and private health services resources by the urban Indians residing in the urban center;

assist such health services resources in providing services to urban Indians; assist urban Indians in becoming familiar with and utilizing such health services resources; provide basic health education, including health promotion and disease prevention education, to urban Indians; establish and implement manpower training programs to accomplish the referral and education tasks; identify gaps between unmet health needs of urban Indians and the resources available to meet such needs; make recommendations to the Secretary and to Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians, and where necessary, provide or enter into contracts for the provision of health care services for urban Indians.

Section 503 also requires the Secretary, acting through the Indian Health Service, to prescribe by regulation the criteria for selecting urban Indian organizations with which to contract. The criteria are to include, among other factors, the extent of unmet health care needs of urban Indians in the urban center involved; the size of the urban Indian population in the urban center involved; the accessibility to, and utilization of, health care services by urban Indians in the urban center involved, other than services provided under title V; the extent, if any, to which the activities outlined in section 503(a) would duplicate any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to title V, or any project funded under title V; the capability of an urban Indian organization to perform the activities outlined in section 503(a) and to enter into a contract with the Secretary under section 503; the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under title V; the appropriateness and likely effectiveness of conducting the activities outlined in section 503(a) in an urban center; and the extent of existing or likely future participation in the activities outlined in section 503(a) by appropriate health and health-related Federal, State, local, and other agencies.

Section 504 authorizes the Secretary of the Department of Health and Human Services acting through the Indian Health Service to enter into contracts with urban Indian organizations under the authority of the Snyder Act of 1921 (25 U.S.C. 13) for which contracts have not been entered into under section 503. The purpose of a contract authorized by section 504 is for the determination of matters described in section 504(b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and to assist the Secretary in determining whether the Secretary should enter into a contract under section 503 with the urban Indian organization with which the Secretary has entered into a contract under section 504. The contract entered into by the Secretary under section 504 is to include requirements that the urban Indian organization successfully undertake to document the health care status and unmet health care needs of urban Indians in the urban center involved and to determine the matters decribed in section 503(b)(2), (3), (4), and (8) with respect to urban Indians in the urban center involved. The urban Indian organization is to complete performance of the contract within one year after the date on which the Secretary and the urban Indian organization enter into the contract. The Secretary may not renew any contract entered into under section 504.

Section 505 directs the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to develop procedures to evaluate compliance with and performance of contracts entered into by urban Indian organizations under title V. The procedures are to include provisions for carrying out the requirement of section 505. The Secretary, acting through the Indian Health Service is to conduct an annual onsite evaluation of each urban Indian organization that has entered into a contract under section 503 for purposes of determining the compliance of each urban Indian organization with the contract and evaluating the performance of each urban Indian organization under the contract. As a result of the evaluations conducted under section 505, if the Secretary determines that an urban Indian organization has not complied with or satisfactorily performed a contract under section 503, the Secretary is directed to attempt to resolve with the urban Indian organization the areas of noncompliance or unsatisfactory performance and modify the contract to prevent future occurrences of any noncompliance or unsatisfactory performance prior to renewing the contract. If the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary is directed not to renew a contract with the urban Indian organization and is authorized to enter into a contract under section 503 with another urban Indian organization that is situated in the same urban center as the urban Indian organization whose contract is not renewed under section 505. In determining whether to renew a contract with an urban Indian organization under section 503, or whether to enter into a contract with an urban Indian organization under section 503 that has completed performance of a contract under section 504, the Secretary is directed to review the records of the urban Indian organization, the reports submitted under section 507, and in the case of a contract renewal under section 503, to consider the results of the on-site evaluations conducted under section 505(b).

Section 506 provides that contracts with urban Indian organizations entered into pursuant to title V are to be in accordance with all Federal contracting laws and regulations except that in the discretion of the Secretary of the Department of Health and Human Service, title V contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 as amended. Section 506 also provides that payments under any title V contract may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of title V. Notwithstanding any provision of law to the contrary, the Secretary is authorized to revise or amend any contract at the request of or with the consent of an urban Indian organization as necessary to carry out the purposes of title V, except that whenever an urban Indian organization requests retrocession of the Secretary for any title V contract, such retrocession will become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request for the urban Indian organization or at such later date as may be mutually agreed to by the Secretary and the organization. Section 506 also authorizes the Secretary to permit an urban Indian organization to utilize existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities in carrying out a contract entered into under title V. Section 506 further provides that contracts with urban Indian organizations and regulations adopted pursuant to title V are to include provisions to assure the fair and uniform provision to urban Indians of services and assistance under the contracts by urban Indian organizations.

Section 507 directs that for each fiscal year during which an urban Indian organization receives or expends funds pursuant to a title V contract, the organization is to submit to the Secretary a quarterly report that includes, in the case of a section 503 contract, information gathered in fulfillment of section 503(a)(10) and (11); information on activities conducted by the organization pursuant to the contract; an accounting of the amount and purposes for which Federal funds were expended; and such other information as the Secretary may request. Section 507 provides that the reports and records of an urban Indian organization with respect to a title V contract are to be subject to audit by the Secretary of the Department of Health and Human Services and the Comptroller General of the United States. Section 507 directs the Secretary to allow as a cost of any section 503 contract, the cost of an annual private audit conducted by a certified public accountant.

Section 508 provides that the authority of the Secretary of the Department of Health and Human Services to enter into title V contracts is to be to the extent and in an amount provided for in appropriation Acts.

Title VI—Organizational Improvements

Section 601 directs the Secretary of the Department of Health and Human Services to establish an automated management information system for the Indian Health Service. The information system is to include a financial management system, a patient care information system for each area served by the Indian Health Service, a privacy component that protects the privacy of patient information held by or on behalf of the Indian Health Service, and a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Indian Health Service. Section 601 further directs the Secretary to submit a report to the Congress setting forth activities that have been undertaken to establish an automated management information system, and the amount of funds that will be needed to complete the implementation of a management information system in succeeding fiscal years, by no later than September 30, 1986. Section 601 provides that notwithstanding any other provision of law, each patient is to have reasonable access to his or her own medical or health records which are held by or on behalf of the Indian Health Service. The directive to the Secretary to establish a management information system is to take effect on the date of enactment of the Indian Health Care Amendments of 1985.

Section 602 redesignates section 601 as section 602 and amends title VI of the Act to add a new section 601. Section 601 provides that in order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as is or may be hereafter provided by Federal statute or treaties, there is estalished within the Public Health Service of the Department of Health and Human Services, the Indian Health Service. The Indian Health Service is to be administered by a Director who is to be appointed by the President and with the advice and consent of the Senate. The Director of the Indian Health Service is to report to the Secretary of the Department of Health and Human Services through the Assistant Secretary of Human Services for Health, and is not to report to or be under the supervision of any other officer or employee of the Department of Health and Human Services. Section 601 directs that the Indian Health Service is to be an agency within the Public Health Service of the Department of Health and Human Services and is not to be an office, component or unit of any other agency of the Department.

The Secretary is directd to carry out through the Director of the Indian Health Service: all functions which were carried out by or under the direction of the individual serving as Director of the Indian Health Service on the day before the date of enactment of the Indian Health Care Amendments of 1985; all functions of the Secretary of the Department of Health and Human Services relating to the maintenance and operation of hospital and health facilities for Indians and the planning for the provision and utilization of health services for Indians; and all health programs under which health care is provided to Indians based upon their status as Indians that are administered by the Secretary, including but not limited to programs under the Indian Health Care Improvement Act; the Snyder Act of 1921 (25 U.S.C. 13); the Act of August 5, 1954 (68 Stat. 674); the Act of August 16, 1957 (71 Stat. 370); and the Indian Self-Determination and Education Assistance Act. Section 601 further provides that notwithstanding any other provision of law, the Indian Health Service is not to be reorganized, altered, or discontinued and any function which is specifically assigned by section 601 to the Director of the Indian Health Service or to the Secretary of the Department of Health and Human Services through the Director for the Indian Health Service is not to be allocated, reallocated, transferred, or delegated to any officer or employee of the Federal Government who is not within the Indian Health Service. The provisions of section 601(d)(1) are not to apply to any action taken by the Director of the Indian Health Service which the Director of the Indian Health Service determines to be appropriate. Section 601 also provides that the Director of the Indian Health Service is to have the authority to appoint and compensate employees for the Indian Health Service in accordance with title 5 of the United States Code except to the extent provided in section 601(d)(2).

The Director of the Indian Health Service is also to enter into contracts for the procurement of goods and services to carry out the functions of the Indian Health Service and to manage, expend, and obligate all funds appropriated for the Indian Health Service.

The authority of the Director of the Indian Health Service to enter into conracts under section 601(d) is to be to such extent and in such amounts as are provided in appropriations Acts of the Congress. Section 602 also amends paragraph (2) of section (2)(b) of Public Law 96-135 to provide that the determination of when and in what circumstances Indian preference laws will apply or not apply is to be made by the Secretary of the Department of Interior or the Secretary of the Department of Health and Human Services and to provide that the determination to be made by either Secretary may only be delegated to an Under Secretary or an Assistant Secretary in the case of the Department of the Interior, and to the Director of the Indian Health Service in the case of the Department of Health and Human Services.

Section 602 also amends section 8336(j) of title 5 of the United States Code to provide that notwithstanding any other provision of law the authority granted to the Secretary of the Department of Health and Human Services under section 8336(j)(3)(B) may be delegated only to the Director of the Indian Health Service. Section 602 also amends section 5313 of title V of the United States Code to add the Director of the Indian Health Service of the Department of Health and Human Services. Section 602 further provides that all personnel, records, equipment, facilities, and interests in property that are administered by the Indian Health Service, or by the Health Resources and Services Administration of the Department of Health and Human Services and that carry out or related to the functions or responsibilities of the Indian Health Service as determined by the Director of the Indian Health Service, on the day before the date on which the amendments made by section 602 take effect are to be transferred to the Indian Health Service as established by the amendment made by section 602(a)(2). The Indian preference laws are not to apply to the transfer of personnel to the Indian Health Service under section 602(c)(1). Section 602 directs the Secretary to submit to the Congress a plan for the implementation of the amendments made by section 602 that takes into account the results of any study conducted by the Office of Technology Assessment or the Comptroller General of the United States relating to the placement of the Indian Health Service within the Public Health Service, and any other relevant study or information relating to the placement of the Indian Health Service within the organizational structure of the Department of Health and Human Services and the functions to be performed by the Indian Health Service, by no later than August 30, 1986. The amendments made by section 602 are to take effect on May 30, 1987.

Title VII—Miscellaneous Provisions

Section 701 amends section 706 of the Indian Health Care Improvement Act to direct the Secretary of the Department of Health and Human Services to enter into an agreement with the Secretary of the Department of the Interior and the Secretary of the Department of Education to coordinate the efforts of their Departments related to alcohol and drug abuse within one year after the date of enactment of the Indian Health Care Amendments of 1985. The agreement is to provide for the identification and coordination of available resources and programs to combat Indian juvenile alcohol and drug abuse through prevention, education, counseling, and referral. The Secretary is to publish the agreement in the Federal Register within eighteen months after the date of enactment of the Indian Health Care Amendments of 1985. Section 706 directs the Secretary, acting through the Indian Health Service in consultation and cooperation with the Secretary of the Interior and the Secretary of Education, to develop a program to provide training in health promotion and disease prevention education; the prevention of alcohol and drug abuse; the identification of juvenile alcohol and drug abusers; and counseling techniques on juvenile alcohol and drug abuse. The training program is to be provided to elementary and secondary teachers and counselors in schools operated by the Bureau of Indian Affairs; in schools operated under contract with the Bureau of Indian Affairs; and in public schools on or near Indian reservations, including public schools in Oklahoma and Alaska with significant numbers of Indian students. The Indian Health Service is authorized to provide the training either directly or through contract with qualified private or public entities. The Secretary of the Interior, acting through the Bureau of Indian Affairs and in consultation with the Indian Health Service, is to review existing literature and reports on juvenile alcohol and drug abuse, including studies and school curricula and any other material relevant to an understanding of the problem of juvenile alcohol and drug abuse and is to make available the results of the review to the schools described in section 706(b).

Section 702 amends section 707 of the Indian Health Care Improvement Act to direct the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to enter into appropriate arrangements with the National Academy of Sciences, in consultation with the Office of Technology Assessment, to conduct a study of health hazards to Indian miners and to Indians living on or near Indian reservations or in Indian communities that result from the development of nuclear resources. It is intended that the Office of Technology Assessment will advise the Congress on the conduct of the study. The study is to include an evaluation of the nature and extent of nuclear-resource-development-related health problems currently exhibited among Indians and the causes of such health problems; an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities; an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplant operation and construction, and nuclear waste disposal; a summary of findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the ten-year period ending on the date of enactment of the Indian Health Care Amendments of 1985 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and an evaluation of the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of nuclear resource development.

To assist the National Academy of Sciences in conducting the study, the Secretary of the Department of Health and Human Services and the Secretary of the Department of the Interior are to furnish at the request of the Academy, any information which the Academy deems necessary for the purpose of conducting the study. The Secretaries are also directed to cooperate with the Academy in obtaining information necessary to carry out the intent of the study. Prior to undertaking the study, the National Academy of Sciences is to consult with the Office of Technology Assessment as to the design of the study and the development of protocols. It is intended that the National Academy of Sciences will periodically report on the progress of the study to the Office of Technology Assessment. Upon completion of the study required by section 707(a), the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, is to develop on the basis of the results of the study, a health care plan to address the health problems studied. The plan is to include methods for diagnosing and treating Indians currently exhibiting nuclear-resource-development-related health problems; provision of preventive care for Indians who may be exposed to such health hazards as a result of nuclear resource development, including the monitoring of the health of individuals who have been or may have been exposed to excessive amounts of radiation or otherwise affected by nuclear development activities that have had or could have a serious impact upon the health of such individuals; and a program of education for Indians who by reason of their work or geographic proximity to nuclear development activities, may experience health problems. Section 720 further amends section 707 to provide that the study is to be submitted to the Congress by no later than the date which is eighteen months after the date of enactment of the Indian Health Care Amendments of 1985. Section 707 is further amended to authorize appropriations in the amount of $750,000 for the purpose of conducting the study authorized by section 707(a). The funds appropriated are to remain available for expenditure until the date which is eighteen months after the date such funds are appropriated.

Section 703 amends section 708 of the Indian Health Care Improvement Act to extend the designation of the State of Arizona as a contract health service delivery area through the fiscal year ending September 30, 1989. Section 708 is further amended to provide that the designation of the State of Arizona as a contract health service delivery area is for the purpose of providing contract care to members of federally recognized tribes of Arizona. Section 703 also amends section 707 to authorize appropriations in the amount of such sums as may be necessary to carry out the provisions of section 708.

Section 704 amends section 709 of the Indian Care Improvement Act to direct that the following California Indians are to be eligible for care from the Indian Health Service: any members of a federally recognized Indian tribe; any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant is currently living in California, is a member of the Indian community served by a local program of the Indian Health Service, and is regarded as an Indian by the community in which such descendant lives; any Indian who holds trust interesting public domain, national forest, or Indian reservation allotments in California; and any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72. Stat. 619) and any descendant of such Indian, provided that the provisions of section 709(4) are not to apply after September 30, 1988.

Section 705 amends section 710 of the Indian Care Improvement Act to direct the Indian Health Service to designate the State of California as a contract health service delivery area for the purpose of providing contract health services to Indians in the State of California, with the exclusion of the countries of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara.

Section 706 amends title VII to add a new section 711. Section 711 directs the Indian Health Service to provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Indian Health Service entered into under the Indian Self-Determination and Education Assistance Act for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations, for employee training, for cost-of-living increases for employees, and for any other expenses relating to the provision of health services on the same basis as such funds are provided to programs and facilities that are operated directly by the Indian Health Service.

Section 707 amends title VII to add a new section 712. Section 712 authorizes the Secretary of the Department of Health and Human Services to remove a member of the National Health Service Corps from a health facility operated by a tribe or tribal organization under a contract with the Indian Health Service entered into under the Indian Self-Determination and Education Assistance Act only if the Secretary has provided written notice of the removal or withdrawal to such tribe or tribal organization at least sixty days before the date on which the contract is entered into or renewed, and the Secretary provides such funds or other personnel as may be necessary to ensure that the Indians who receive services from the the National Health Service Corps members will not experience a reduction in services.

Section 708 amends title VII to add a new section 713. Section 713 authorizes the Secretary of the Department of Health and Human Services to provide or authorize the provision of medical care, treatment, or benefits by the Indian Health Service to persons who are not otherwise eligible for such services in health facilities maintained by the Indian Health Service or contracted under the Indian Self-Determination and Education Assistance Act (Public Law 93–638) or through contract health care services, subject to the limitations of section 713. Section 713 provides that any individual who has not attained nineteen years of age; is the natural or adoped child (including foster- and step-child), legal ward, or orphan of an eligible Indian; and is not otherwise eligible for the medical care, treatment, or benefits of the Indian Health Service; is to be eligible for all such services on the same basis and subject to the same rules that apply to eligible Indians until such individual attains nineteen years of age. The existing potential medical needs of all such individuals is to be taken into consideration by the

Indian Health Service in determining the need for or the allocation of the health resources of the Indian Health Service. If such an individual has been determined to be legally incompetent prior to attaining nineteen years of age, such individual is to remain eligible for such services until one year after the date such disability has been removed.

Section 713 further provides than non-Indian spouses of eligible Indian and spouses of Indian descent who are not otherwise eligible for the medical care, treatment, or benefits of the Indian Health Service shall not be eligible for such service unless they are made eligible, as a class, by an appropriate resolution of the governing body of the relevant Indian tribe. The medical needs of persons made eligible under section 713(a)(3) are not to be taken into consideration by the Indian Health Service in determining the need for or allocation of its health resources. Upon the request of an Indian tribe, or in the case of a multi-tribal service area, all the Indian tribes included within the service area of any service unit of the Indian Health Service, the Secretary may authorize the medical care and treatment of otherwise ineligible person residing within the service area in health facilities maintained and operated by the Indian Health Service. Persons receiving medical care and treatment by reason of section 713(b)(1) are to be liable for the payment of services rendered to them under a fee schedule adopted by the Secretary and which in the judgment of the Secretary, will result in reimbursement in an amount not less than the actual cost of providing the service. Fees so collected, including Medicare or Medicaid reimbursements under titles XVIII or XIX of the Social Security Act, are to be credited to the account of the facility providing the service and are to be used solely for the provision of health services with the facility. Except as provided in section 713(b)(2)(B), if the governing body any Indian tribe revoked its concurrence to the provision of services under section 713(b)(1)(A), the Secretary's authority to provide services is to terminate at the end of the fiscal year following the fiscal year in which a revocation is adopted. In California, in the case of a multi-tribal service area, unless fifty-one percent or more of the Indian tribes in the service area revoke their concurrence to the provision of service under section 713(b)(1)(A), the authority to provide services in not be affected.

In the case of health facilities operated directly by the Indian Health Service, medical care and treatment may be provided to individuals under section 713(b) only if the Secretary and the affected tribe or tribes have jointly determined that the provision of such service will not result in a denial or diminution of services to eligible Indians, and there is no reasonable alternative health facility or service, within or without the service unit area, available to meet the medical needs of such individuals. In the case of health facilities operated under a contract entered into under the Indian Self-Determination and Education Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under such contract is authorized to determine the eligibility for such health services of individuals who are not otherwise eligible for such health services. Such determination is to be in accordance with the requirements of section 713. The Indian Health

Service is authorized to continue to provide medical care, treatment, and benefits to individuals not provided services under section 713 (a) or (b) in order to achieve stability in a medical emergency, prevent the spread of a communicable disease or otherwise deal with a public health hazard, provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum, or provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

Section 713 authorizes the extension of hospital privileges in health facilities operated and maintained by the Indian Health Service or operated under a contract entered into under the Indian Self-Determination and Education Assistance Act to non-Indian Health Service health care practitioners who provide services to persons described in section 713 (a) or (b). Such non-Indian Health Service health care practitioners are not to be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28 of the United States States Code relating to Federal tort claims even if such practitioners provide services to eligible persons as part of the conditions under which hospital privileges are extended. Section 708 also amends title VII by adding a new section 714. Section 714 directs the Secretary of the Department of Health and Human Services to develop and begin implementation of a plan by not later than January 1, 1987, to achieve the following objectives by January 1, 1991: reduction of the rate of Indian infant mortality in each area office of the Indian Health Service to the lower of twelve deaths per one thousand live births or the rate of infant mortality applicable to the United States population as a whole; reduction of the rate of maternal mortality in each area office of the Indian Health Service to the lower of five deaths per one hundred thousand live births or the rate of maternal mortality applicable to the United States population as a whole; and reduction of the rate of fetal alcohol syndrome and fetal alcohol effect associated with maternal consumption of alcohol to the lower of one per one thousand live births, or the rate of fetal alcohol syndrome and fetal alcohol effect applicable to the United States population as a whole.

The President is to include with the budget submitted under section 1105 of title 31 of the United States Code for each fiscal year, a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in section 714(a). Section 708 further amends title VII by adding a new section 715. Section 715 directs the Secretary of the Department of Health and Human Services acting through the Indian Health Service and in conjunction with the State of Alaska and the Centers for Disease Control of the Department of Health and Human Services, to complete the implementation of a program by no later than the date which is one year after the date of enactment of the Indian Health Care Amendments of 1985, to provide for screening and reporting of cases of, vaccinations for the prevention of, and control of the incidence of Hepatitis B in Alaska.

The Secretary is to submit a report to the Congress by no later than December 31, 1987, concerning the activities carried out under the program. The report is to include a description of any activities which need to be carried out to control the incidence of Hepatitis-B in Alaska on the date the report is submitted, and a schedule for completion of such activities. The President is to include in the budget submitted under section 1105(a) of title 31 of the United States Code for each of the fiscal years succeeding the fiscal year in which the Indian Health Care Amendment of 1985 are enacted, a request for budget authority for and estimates of outlays for a program to control the incidence of Hepatitis B in Alaska. Section 708 also amends title VII of the Act by adding a new section 716. Section 716 directs the Secretary of the Department of Health and Human Services to examine the feasibility of entering into an arrangement with the Administrator of the Veterans' Administration pursuant to the authority of subchapter IV of chapter 81 of title 38 of the United States Code for the sharing of medical resources and services between the Indian Health Service and the Veterans' Administration.

The Secretary is to submit a report on the findings made under section 716(a) to the Administrator of the Veterans' Administration. The Administrator of the Veterans' Administration is to include the Secretary's report with the report that the Administrator of the Veterans' Administration is required to submit under section 5057 of title 38 of the United States Code. In carrying out the provisions of section 716, the Secretary is to take no action nor make any recommendation that would impair the entitlement of any Indian to receive health services, as an Indian, through the Indian Health Service, or the entitlement of any Indian who is a veteran to receive health services as a veteran through the Veterans' Administration. Section 708 further amends title VII of the Act to add a new section 717. Section 717 directs the Secretary of the Department of Health and Human Services acting through the Indian Health Service to providee contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana. Section 708 amends title VII of the Act to add a new section 718. Section 718 directs the Secretary of the Department of Health and Human Services to conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders. In conducting the study, the Secretary is to consult with the Commissioner of the Administration for Native Americans, the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, the Director of the Indian Health Service, leaders in the field of health care, and representatives of Native Hawaiians and other Native American Pacific Islanders.

The Secretary is to submit a report on the study to the Congress by no later than the date that is one year after the date of enactment of the Indian Health Care Amendments of 1985. The report is to include an assessment of the access of and barriers to Native Hawaiians and other Native American Pacific Islanders in receiving physical and mental health care services, an assessment of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders, and specific recommendations for the development of a national strategy to address such needs. Section 708 further amends title VII to add a new section 719. Section 719 directs the Secretary of the Department of Health and Human Services to establish as a demonstration project in the State of Hawaii, a Native Hawaiian program for health promotion and disease prevention for the purpose of exploring ways to meet the unique health care needs of Native Hawaiians. The program is to provide necessary preventive-oriented health services, including health education and mental health care; develop innovative training and research projects; establish cooperative relationships with the leadership of the Native Hawaiian community; and ensure that a continuous effort is made to establish programs that can be of direct benefit to other Native American people.

The Secretary is authorized to enter into contracts with Native Hawaiian organizations recognized by the Governor of the State of Hawaii and institutions that serve the needs of Native Hawaiians for the purpose of assisting the program in meeting the objectives described in section 719(b)(1). The Secretary is to submit an annual report to the Congress for each of the fiscal years 1986, 1987, and 1988 on the status and accomplishments of the program during each fiscal year. There is authorized to be appropriated $500,000 for each of the fiscal years 1986, 1987, and 1988, for the purpose of carrying out the provisions of section 719. Section 719 also amends section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) as amended by section 203(b) of the Indian Health Care Amendments of 1985 to add the following new definitions. The term "Native Hawaiian" means any individual who has any ancestors that were natives, prior to 1778, of the area that now comprises the State of Hawaii. The term "Native American Pacific Islander" means any Native Hawaiian; any of the indigenous people residing in Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands; or any individual whose direct ancestors are from Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands.

Section 709 amends section 105(e) of the Indian Self-Determination and Education Assistance Act to extend to 1988, the termination date of the authority for Federal employees to elect to retain certain of their employee rights and benefits when they become employed by a tribe. Section 709 also amends section 210(a)(5)(B)(i) of the Social Security Act and section 3121(b)(5)(B)(i) of the Internal Revenue Code of 1954 to permit persons who have left Federal employment to work for Indian tribes or tribual organizations or Alaska Native entities under the provisions of the Indian Self-Determination and Education Assistance Act to be exempted from the requirements that they participate in the Social Security program when a tribe retrocedes a contract or the Secretary of the Department of Health and Human Services reassumes the health service function.

Section 710 provides that if any provision of the Indian Health Care Amendments of 1985, or any amendment made by the Indian Health Care Amendments of 1985, or the application of any provision or amendment made by the Indian Health Care Amendments of 1985 to any person or circumstances is held to be invalid, the remainder of the Indian Health Care Amendments of 1985, the amendments made by the Indian Health Care Amendments of 1985, and the application of such provision to persons or circumstances other than those to which it is held invalid is not to be affected thereby.

COST AND BUDGETARY CONSIDERATIONS

The cost estimates for S. 277 as provided by the Congressional Budget Office are outlined below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 15, 1985.

Hon. MARK ANDREWS,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 277, the Indian Health Care Amendments of 1985, as ordered reported by the Senate Select Committee on Indian Affairs on May 2, 1985.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

JAMES BLUM
(For Rudolph G. Penner, Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: S. 277.
2. Bill title: Indian Health Care Amendments of 1985.
3. Bill status: As ordered reported by the Senate Select Committee on Indian Affairs on May 2, 1985.
4. Bill purpose: S. 277 would revise and extend the Indian Health Care Improvement Act.
5. Estimated cost to the Federal Government:

AMOUNTS SUBJECT TO APPROPRIATIONS ACTION

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Authorization Levels:					
Health Professions Recruitment Program for Indians	0.6	0.7	0.7	0.8	
Health Professions Prep Scholarship Program for Indians	4.7	5.4	6.1	6.8	
Health Professions Scholarship Program	7.0	8.1	9.2	10.3	
Indian Health Service Extern Program	0.4	0.4	0.5	0.5	
Community Health Representative Program [1]	26.6	27.4	28.3	29.3	30.4
Indian Health Care Improvement Fund	29.0	28.0	46.0	46.0	
Indian Catastrophic Health Emergency Fund [1]	12.0	12.0	12.0	12.0	
Water and Sanitation	5.9	5.9	5.9	5.9	
Access to Health Services	1.5	2.0	0.5	0.5	
Health Services for Urban Indians [1]	10.2	10.5	10.9	11.3	11.7
Training of BIA Teachers [1]	(2)	(2)	(2)	(2)	
Study of Health Hazards to Indians from Nuclear Development	0.5	0.3			
Arizona as a Contract Health Service Delivery Area [1]	14.0	14.4	14.9	15.4	
Demonstration Project	0.5	0.5	0.5		

AMOUNTS SUBJECT TO APPROPRIATIONS ACTION—Continued

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Hepatitis-B Screening and Vaccination in Alaska[1]		4.0	([2])	([2])	([2])
Total Estimated Authorization Levels	112.9	119.6	135.5	138.8	42.1
Estimated Outlays:					
Health Professions Recruitment Program for Indians	0.4	0.6	0.7	0.8	0.2
Health Professions Prep Scholarship Program for Indians	3.5	5.0	5.9	6.7	1.8
Health Professions Scholarship Program	5.2	7.5	8.9	10.2	2.7
Indian Health Service Extern Program	0.3	0.4	0.5	0.5	0.1
Community Health Representative Program	19.9	25.9	28.0	29.7	8.0
Indian Health Care Improvement Fund	21.7	26.9	41.4	45.9	12.2
Indian Catastrophic Health Emergency Fund	9.0	11.4	12.0	12.3	3.3
Water and Sanitation	4.4	5.6	5.9	6.1	1.6
Access to Health Services	1.1	1.8	0.8	0.6	0.2
Health Services for Urban Indians	7.6	9.9	10.8	11.5	3.1
Training of BIA Teachers	([2])	([2])	([2])	([2])	...
Study of Health Hazards to Indians from Nuclear Development	0.5	0.3	...	...	...
Arizona as a Contract Health Service Delivery Area	10.5	13.6	14.7	15.6	4.2
Demonstration Project	0.4	0.5	0.5	0.1	...
Hepatitis B Screening and Vaccination in Alaska		3.0	0.8	0.2	...
Total Estimated Outlays	84.5	112.4	130.9	140.2	37.4
Direct Spending Provisions:					
Medicare:					
Budget Authority	0.2	0.2	0.1	0.1	...
Estimated Outlays	0.8	0.8	0.8	0.8	0.8
Grand Total:					
Budget Authority/Authorization Levels	113.1	119.8	135.6	138.9	42.1
Estimated Outlays	85.3	113.2	131.7	141.0	38.2

[1] Estimated Authorization Levels.

[2] Less than $500,000.

NOTE.—The costs of this bill fall within function 550.

Basis of Estimate: Most authorization levels are stated in the bill. CBO assumes that all stated authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

The bill establishes two current Indian Health Service (IHS) activities as permanent programs that would be funded under the permanent, unspecific authorization of the Snyder Act of 1921. Under the bill, the Community Health Representative program and Health Services for Urban Indians would both be permanently authorized. Specific reauthorization of these programs would no longer be necessary. The authorization levels shown in the table for these programs reflect the permanent addition to the current level of IHS services. These levels were estimated by increasing the 1985 appropriation levels for these activities by the appropriate inflator.

The Indian Health Care Improvement Fund authorization levels for fiscal years 1986 through 1989 are stated in the bill. These funds would be used to raise 121 tribes to a level where they have a 40 percent deficiency of health resources. According to the IHS, $47 million is needed to accomplish this. The Indian Health Care Improvement Fund authorization levels stated in the bill for fiscal years 1986 and 1987 total $57 million. It is the Committee's intent that the additional $10 million of authorization be used to update tribal specific health plans. The fiscal year 1988 and 1989 authorizations would be used to begin to raise an additional 99 tribes to a 20 percent deficiency level.

The bill also authorizes $12 million in fiscal year 1986 for the Indian Catastrophic Health Emergency Fund. It authorizes such sums as may be necessary in fiscal years 1987, 1988, and 1989 to return the Fund to a level of $12 million. CBO assumes that this authorization would not allow repeated draining and refilling of the Fund during any one fiscal year. Rather, the authorization will simply limit aggregate annual appropriations to the Fund to $12 million.

The bill provides such sums as may be necessary through 1989 to train teachers on or near reservations in juvenile alcohol and drug abuse prevention and counseling. The costs associated with this training are expected to be less than $1 million each year.

S. 277 would also make the state of Arizona a Contract Health Service delivery area. Contract health care delivered to Indians anywhere in the state would be paid for by the IHS. The estimated authorization level for this provision is based on the estimated number of Indians in Arizona not currently eligible for contract health care services and on an average cost for contract care.

No additional appropriations were authorized in this bill for Hepatitis-B screening and vaccination for Alaska natives, although the bill language provides for these services. This activity is currently authorized through 1986 at which point some 40,000 people will have been vaccinated. CBO estimates that an additional appropriation of $4 million would be needed in 1987 to screen the remaining population, and an amount less than $1 million in each year thereafter to maintain newborn vaccinations.

This bill would expand the types of Indian health facilities eligible for Medicare reimbursement. Medicare facilities would be expanded to include health centers, health stations, and home health agencies. Because most facilities are already covered by Medicare, this legislation would have only a very small cost.

The bill also newly designates California as a contract health service delivery area and provides funding for employee training, cost-of-living adjustments and maintenance and repair in tribally operated IHS programs and facilities. The bill authorizes preventive health services and the development and implementation of a plan to reduce infant and maternal mortality rates among Indians. It also authorizes a study on Native Hawaiian health care needs. The Secretary of HHS is also authorized to establish a management information system for IHS. CBO has not included an estimate for these new activities as it is the Committee's intent that funds otherwise appropriated in 1986 through 1989 be redirected to include these activities.

6. Estimated cost to state and local governments: The budgets of state and local governments would not be affected directly by the enactment of this bill.

7. Estimate comparison: None.

8. Previous CBO estimate: CBO prepared an estimate for H.R. 1426 as ordered reported by the House Committee on Interior and

Insular Affairs, on May 3, 1985. Both bills amend the Indian Health Care Improvement Act, but provisions in the two bills differ.

9. Estimate prepared by: Carmela Pena.

10. Estimate approved by:

C.G. NUCKOLS
(For James L. Blum, Assistant Director for Budget Analysis).

REGULATORY IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the provisions of the bill.

The Committee believes that S. 277 will have minimal regulatory or paperwork impact.

EXECUTIVE COMMUNICATIONS

The Committee requested a legislative report on S. 277 from the Department of Health and Human Services on February 1, 1985. The Committee has not received a legislative report on S. 277 from the Department of Health and Human Services.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by S. 277 are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC LAW 94-437

To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Care Improvement Act."

FINDINGS

SEC. 2. The Congress finds that—

(a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

(c) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

(d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States. For example, for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater, and the infant death rate approximately 20 per centum greater.

(c) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.

(f) Further improvement in Indian health is imperiled by—

(1) inadequate, outdated, inefficient, and undermanned facilities. For example, only twenty-four of fifty-one Indian Health Service hospitals are accredited by the Joint Commission on Accreditation of Hospitals; only thirty-one meet national fire and safety codes; and fifty-two locations with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional service;

(2) shortage of personnel. For example, about one-half of the Service hospitals, four-fifths of the Service hospital outpatient clinics, and one-half of the Service health clinics meet only 80 per centum of staffing standards for their respective services;

(3) insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services, and services available through contracts with private physicians, clinics, and agencies. For example, about 90 per centum of the surgical operations needed for otitis media have not been performed, over 57 per centum of required dental services remain to be provided, and about 98 per centum of hearing aid requirements are unmet;

(4) related support factors. For example, over seven hundred housing units are needed for staff at remote Service facilities;

(5) lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climate conditions; and

(6) lack of safe water and sanitary waste disposal services. For example, over thirty-seven thousand four hundred existing and forty-eight thousand nine hundred and sixty planned replacement and renovated Indian housing units need new or upgraded water and sanitation facilities.

(g) The Indian people's growth of confidence in Federal Indian health services is revealed by their increasingly heavy use of such services. Progress toward the goal of better Indian health is dependent on this continued growth of confidence. Both such progress and such confidence are dependent on improved Federal Indian health services.

DECLARATION OF POLICY

SEC. 3. The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

DEFINITIONS

SEC. 4. For purposes of this Act—

(a) "Secretary", unless otherwise designated, means the Secretary of Health and Human Services.

(b) "Service" means the Indian Health Service.

(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe as defined in subsection (d) hereof, except that, for the purpose of sections 102, 103, and 201(c)(5), such terms shall means any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant of the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection (c) (1) through (4) of this section.

(g) "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

[(i) "Rural Indian" means any individual who resides in a rural community as defined in subsection (j), who is an Indian within the meaning of subsection (c), and who is not otherwise eligible to receive health services from the Service.

[(j) "Rural community" means any community that—

[“(1) is not located on a Federal Indian reservation or trust area;

[“(2) is not an Alaskan Native village;

[“(3) is not an urban center; and

[“(4) has a sufficient rural Indian population with unmet health needs, as determined by the Secretary, to warrant assistance under title V of this Act.

[(k) "Rural Indian organization" means a nonprofit corporate body governed by a board of directors controlled by rural Indians and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).]

(i) "Area office" means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(j) "Service unit" means—

(1) an administrative entity within the Indian Health Service, or

(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act.

through which services are provided, directed or by contract, to the eligible Indian population within a defined geographic area.

(k) "Health promotion" includes—

(1) cessation of tobacco smoking,

(2) reduction in the misuse of alcohol and drugs,

(3) improvement of nutrition,

(4) improvement in physical fitness,

(5) family planning, and

(6) control of stress.

(l) "Disease prevention" includes—

(1) immunizations,

(2) control of high blood pressure,

(3) control of sexually transmittable diseases,

(4) prevention and control of diabetes,

(5) pregnancy and infant care (including prevention of fetal alcohol syndrome),

(6) control of toxic agents,

(7) occupational safety and health,

(8) accident prevention,

(9) fluoridation of water, and

(10) control of infectious agents.

(m) "Native Hawaiian" means any individual who has any ancestors that were natives, prior to 1778, of the area that now comprises the State of Hawaii.

(n) "Native American Pacific Islander" means—

(1) any Native Hawiian,

(2) any of the indigenous people residing in Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands; or

(3) any individual whose direct ancestors are from Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Northern Mariana Islands.

TITLE I—INDIAN HEALTH MANPOWER

PURPOSE

SEC. 101. The purpose of this title is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians.

HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 102. (a) The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them (A) to enroll in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions; or (B), if they are not qualified to enroll in any such school, to undertake such post-secondary education or training as may be required to qualify them for enrollment;

(2) publicizing existing sources of financial aid available to Indians enrolled in any school referred to in clause (1)(A) of this subsection or who are undertaking training necessary to qualify them to enroll in any such school; or

(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians, and the subsequent pursuit and completion by them of courses of study, in any school referred to in clause (1)(A) of this subsection.

(b)(1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe: *Provided,* That the Secretary shall give a preference to application submitted by Indian tribes or tribal organizations.

(2) The amount of any grant under this section shall be determined by the Secretary. Payments pursuant to grants under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary finds necessary.

[(c) For the purpose of making payments pursuant to grants under this section, there are authorized to be appropriated $900,000 for fiscal year 1978, $1,500,000 for fiscal year 1979, and $1,800,000 for fiscal year 1980. There are authorized to be appropriated to carry out this section $2,300,000 for the fiscal year ending September 30, 1981, $2,600,000 for the fiscal year ending September 30, 1982, $3,000,000 for the fiscal year ending September 30, 1983, and $3,500,000 for the fiscal year ending September 30,1984.]

(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $600,000 for fiscal year 1986,

(2) $650,000 for fiscal year 1987,

(3) $700,000 for fiscal year 1988, and

(4) $750,000 for fiscal year 1989.

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

SEC. 103. (a) The Secretary, acting through the Service, shall make scholarship grants to Indians who—

(1) have successfully completed their high school education or high school equivalency; and

(2) have demonstrated the capability to successfully complete courses of study in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions.

(b) Scholarship grants made pursuant to this section shall be for the following purposes:

"(1) Compensatory preprofessional education of any grantee, such scholarship not to exceed two years.

"(2) Pregraduate education of any grantee leading to a baccalaureate degree in an approved premedicine, predentistry, preosteopathy, preveterinary medicine, preoptometry, or prepodiatry curriculum, such scholarship not to exceed four years.

(c) Scholarship grants made under this section may cover costs of tuition books, transportation, board, and other necessary related [expenses] *expenses of a grantee while attending school full time.*

[(d) There are authorized to be appropriated for the purpose of this section: $800,000 for fiscal year 1978, $1,000,000 for fiscal year 1979, and $1,300,000 for fiscal year 1980. There are authorized to be appropriated to carry out this section $3,510,000 for the fiscal year ending September 30, 1981, $4,000,000 for the fiscal year ending September 30, 1982, $4,620,000 for the fiscal year ending September 30, 1983, and $5,300,000 for the fiscal year ending September 30, 1984.]

(d) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution.

(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $4,700,00 for fiscal year 1986

(2) $5,400,00 for fiscal year 1987

(3) $6,100,00 for fiscal year 1988, and

(4) $6,800,00 for fiscal year 1989.

INDIAN HEALTH SCHOLARSHIP PROGRAM

SEC. 338G. [294y-1] (a) In addition to the sums authorized to be appropriated under [section 756(a)] *section 338F(a)* to carry out the Scholarship Program, there are authorized to be appropriated $5,450,000 for the fiscal year ending September 30, 1978, $6,300,000 for the fiscal year ending September 30, 1979, $7,200,000 for the fiscal year ending September 30, 1980, $9,000,000 for the fiscal year ending September 30, 1981, $10,300,000 for the fiscal year ending September 30, 1982, $11,800,000 for the fiscal year ending September 30, 1983, [and] $13,600,000 for the fiscal year ending September 30, 1984, *$7,000,000 for the fiscal year ending September 30, 1986, $8,100,000 for the fiscal year ending September 30, 1987, $9,234,000 for the fiscal year ending September 30, 1988, and $10,300,000 for the fiscal year ending September 30, 1989,* to provide scholarships under the Scholarship Program to provide physicians, osteopaths, dentists, veterinarians, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health professionals to provide services to Indians *and, subject to available appropriations, Native Hawaiians.* Such scholarships shall be designated "Indian Health Scholarships" and shall be made in accordance with this subpart, except as provided in subsection (b).

(b)(1) The Secretary, acting through the Indian Health Service, shall determine the individuals who shall receive the Indian Health Scholarships, shall accord priority to applicants who are Indians, and shall determine the distribution of the scholarships on the basis of the relative needs of Indians *and, subject to available appropriations, Native Hawaiians* for additional services by specific health professions.

[(2) The active duty service obligation prescribed in the written contract entered into under this subpart shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of the applicable profession if, as determined by the Secretary in accordance with guidelines promulgated by the Secretary, such practice is situated in a physican or other health professional shortage area and addresses the health care needs of a substantial number of Indians.]

(2)(A) The active duty service obligation prescribed in the written contract entered into under this subpart shall be met by an Indian recipient of an Indian Health Scholarship by service—

(i) in the Indian Health Service;

(ii) in a program conducted under a contract entered into under the Indian Self-Determination and Education Assistance Act;

(iii) in a program assisted under title V of the Indian Health Care Improvement Act; or

(iv) in the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physican or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

(B) The active duty service obligation prescribed in the written contract entered into under this subpart shall be met by a Native Hawaiian recipient of an Indian Health Scholarship by service—

(i) in the Indian Health Service;

(ii) in a program conducted under contract entered into under the Indian Self-Determination and Education Assistance Act;

(iii) in a program assisted under title V of the Indian Health Care Improvement Act; or

(iv) in the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians or Native Hawaiians.

(3) The Secretary shall not deny scholarship assistance to any eligible applicant under this section solely upon the basis of the applicant's scholastic achievement if such applicant has been admitted to an accredited educational institution to pursue a course of study described in subsection (a).

(c)(1) The term "Indian" has the meaning given to such term by section 4(c) of the Indian Health Care Improvement Act and includes the individuals described in clauses (1) through (4) of section 4(c) of such Act.

(2) The term "Native Hawaiian" means any individual who has any ancestors that were natives, prior to 1778, of the area which now comprises the State of Hawaii.

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 105. (a) Any individual who receives a scholarship grant pursuant to section 104 shall be entitled to employment in the Service during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship grant.

(b) Any individual enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions may be employed by the Service during any nonacademic period of the year. Any such employment shall not exceed one hundred and twenty days during any calendar year.

(c) Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department of Health, Education, and Welfare.

[(d) There are authorized to be appropriated for the purpose of this section: $600,000 for fiscal year 1978, $800,000 for fiscal year 1979, and $1,000,000 for fiscal year 1980. There are authorized to be appropriated to carry out this section $990,000 for the fiscal year ending September 30, 1981, $1,140,000 for the fiscal year ending September 30, 1982, $1,310,000 for the fiscal year ending September 30, 1983, and $1,510,000 for the fiscal year ending September 30, 1984.]

(d) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $350,000 for fiscal year 1986,
(2) $400,000 for fiscal year 1987,
(3) $450,000 for fiscal year 1988, and
(4) $500,000 for fiscal year 1989.

CONTINUING EDUCATION ALLOWANCES

SEC. 106. (a) In order to encourage physicians, dentists, and other health professionals to join or continue in the Service and to provide their services in the rural and remote areas where a significant portion of the Indian people resides, the Secretary, acting through the Service, may provide allowances to health professionals employed in the Service to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

(b) There are authorized to be appropriated for the purpose of this section: $100,000 for fiscal year 1978, $200,000 for fiscal year 1979, and $250,000 for fiscal year 1980. For fiscal year 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

SEC. 107. (a) Under the authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary shall maintain a Community Health Representative Program under which the Service—

(1) provides for the training of Indians as health paraprofessionals, and

(2) uses such paraprofessionals in the provision of health care to Indian communities.

(b) The Secretary, acting through the Community Health Representative Program of the Service, shall—

(1) provide a high standard of paraprofessional training to Community Health Representatives provide quality health care to the Indian communities served by such Program,

(2) in order to provide such training, develop a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care,

(B) provides instruction and practical experience in health promotion and disease prevention activities, particularly—

(i) nutrition,
(ii) physical fitness,

(iii) weight control,

(iv) cessation of tobacco smoking,

(v) stress management,

(vi) control of alcohol and drug abuse (including prevention of fetal alcohol syndrome),

(vii) control of high blood pressure,

(viii) prevention of lifestyle-related accidents,

(ix) prevention and management of hearing and vision problems, and

(x) prevention of diabetes, and

(C) provides instruction in the latest and most effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits,

(3) develop a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for such continuing education,

(4) develop and maintain a system that provides close supervision of Community Health Representatives,

(5) develop a system under which the work of Community Health Representatives is reviewed and evaluated, and

(6) ensure that the provision of health care, health promotion, and disease prevention activities are consistent with the traditional health care practices and cultural values of the Indian tribes served by such Program.

TITLE II—HEALTH SERVICES

[HEALTH SERVICES

[SEC. 201. (a) For the purpose of eliminating backlogs in Indian health care services and to supply known, unmet medical, surgical, dental, optometrical, and other Indian health needs, the Secretary is authorized to expend, through the Service, over the seven-fiscal-year period beginning after the date of the enactment of this Act the amounts authorized to be appropriated by subsection (c). Funds appropriated pursuant to this section for each fiscal year shall not be used to offset or limit the appropriations required by the Service under other Federal laws to continue to serve the health needs of Indians during and subsequent to such seven-fiscal-year period, but shall be in addition to the level of appropriations provided to the Service under this Act and such other Federal laws in the preceding fiscal year plus an amount equal to the amount required to cover pay increases and employee benefits for personnel employed under this Act and such laws and increases in the costs of serving the health needs of Indians under this Act and such laws, which increases are cuased by inflation.

[(b) The Secretary, acting through the Service, is authorized to employ persons to implement the provisions of this section during the seven-fiscal-year period in accordance with the schedule provided in subsection (c). Such positions authorized each fiscal year pursuant to this section shall not be considered as offsetting or limiting the personnel required by the Service to serve the health needs of Indians during and subsequent to such seven-fiscal-year period but shall be in addition to the positions authorized in the previous fiscal year.

[(c) The following amounts and positions are authorized, in accordance with the provisions of subsections (a) and (b), for the specific purposes noted:

[(1) Patient care (direct and indirect): sums and positions as provided in subsection (c) for fiscal year 1978, $8,500,000 and two hundred and twenty-five positions for fiscal year 1979, and $16,200,000 and three hundred positions for fiscal year 1980. There are authorized to be appropriated $20,250,000 for the fiscal year ending September 30, 1981, $23,000,000 for the fiscal year ending September 30, 1982, $26,500,000 for the fiscal year ending September 30, 1983, and $30,500,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(2) Field health, excluding dental care (direct and indirect): sums and positions as provided in subsection (c) for fiscal year 1978, $3,350,000 and eighty-five positions for fiscal year 1979, and $5,550,000 and one hundred and thirteen positions for fiscal year 1980. There are authorized to be appropriated $6,400,000 for the fiscal year ending September 30, 1981, $7,350,000 for the fiscal year ending September 30, 1982, $8,450,000 for the fiscal year ending September 30, 1983, and $9,700,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(3) Dental care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $1,500,000 and eighty positions for fiscal year 1979, and $1,500,000 and fifty positions for fiscal year 1980. There are authorized to be appropriated $1,875,000, for the fiscal year ending September 30, 1981, $2,150,000 for the fiscal year ending September 30, 1982, $2,500,000 for the fiscal year ending September 30, 1983, and $2,875,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(4) Mental health: (A) Community mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,300,000 and thirty positions for fiscal year 1979, and $20,000,000 and thirty positions for fiscal year 1980. There are authorized to be appropriated $2,500,000 for the fiscal year ending September 30, 1981, $2,875,000 for the fiscal year ending September 30, 1982, $3,300,000 for the fiscal year ending September 30, 1983, and $3,800,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(B) Inpatient mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $100,000 and fifteen positions for fiscal year 1979, and $600,000 and fifteen positions for fiscal year 1980. There are authorized to be appropriated $750,000 for the fiscal year ending September 30, 1981, $870,000 for the fiscal year ending September 30, 1982, $1,000,000 for the fiscal year ending September 30, 1983, and $1,150,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(C) Model dormitory mental health services: sums and position as provided in subsection (e) for fiscal year 1978, $1,250,000 and fifty positions for fiscal year 1979, and $1,875,000 and fifty positions for fiscal year 1980. There are authorized to be appropriated $2,350,000 for the fiscal year ending September 30, 1981, $2,700,000 for the fiscal year ending September 30, 1982, $3,100,000 for the fiscal year ending September 30, 1983, and $3,600,000 for the fiscal year ending September 30, 1984, and such further positions are authorized as may be necessary for each such fiscal year.

[(D) Therapeutic and residential treatment centers: sums and positions as provided in subsection (e) for fiscal year 1978, $300,000 and ten positions for fiscal year 1979, and $100,000 and five positions for fiscal year 1980. There are authorized to be appropriated $460,000 for the fiscal year ending September 30, 1981, $525,000 for the fiscal year ending September 30, 1982, $600,000 for the fiscal year ending September 30, 1983, and $690,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(E) Training of traditional Indian practitioners in mental health: sums as provided in subsection (e) for fiscal year 1978, $150,000 for fiscal year 1979, and $200,000 for fiscal year 1980. There are authorized to be appropriated $250,000 for the fiscal year ending September 30, 1981, $285,000 for the fiscal year ending September 30, 1982, $325,000 for the fiscal year ending September 30, 1983, and $375,000 for the fiscal year ending September 30, 1984.

[(5) Treatment and control of alcoholism among Indiana: $4,000,000 for fiscal year 1978, $9,000,000 for fiscal year 1979, and $9,200,000 for fiscal year 1980. There are authorized to be appropriated $16,500,000 for the fiscal year ending September 30, 1981, $19,000,000 for the fiscal year ending September 30, 1982, $22,000,000 for the fiscal year ending September 30, 1983, and $25,100,000 for the fiscal year ending September 30, 1984.

[(6) Maintenance and repair (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $3,000,000 and twenty positions for fiscal year 1979, and $4,000,000 and thirty positions for fiscal year 1980. There are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1981, $5,750,000 for the fiscal year ending September 30, 1982, $6,600,000 for the fiscal year ending September 30, 1983, and $7,600,000 for the fiscal year ending September 30, 1984, and such further additional positions are authorized as may be necessary for each such fiscal year.

[(d) The Secretary, acting through the Service, shall expend directly or by contract not less than 1 per centum of the funds appropriated under the authorizations in each of the clauses (1) through (5) of section (c) for research in each of the areas of Indian health care for which such funds are authorized to be appropriated.

[(e) For fiscal year 1978, the Secretary is authorized to apportion not to exceed a total of $10,025,000 and 425 positions for the programs enumerated in clauses (c) (1) through (4) and (c)(6) of this section.]

IMPROVEMENT OF INDIAN HEALTH STATUS

Sec. 201. (a) The Secretary is authorized to expend funds which are appropriated pursuant to subsection (j), through the Service, for the purposes of—

(1) raising the health status of Indians to zero deficiency,

(2) eliminating backlogs in the provision of health care services to Indians,

(3) meeting the health needs of Indians in an efficient and equitable manner, and

(4) augmenting the ability of the Service to meet the following health service responsibilities:

(A) clinical care (direct and indirect) including clinical eye and vision care;

(B) preventive health;

(C) dental care (direct and indirect);

(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners;

(E) emergency medical services;

(F) treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians;

(G) home health care;

(H) community health representatives; and

(I) maintenance and repair.

(b)(1) Any funds appropriated pursuant to subsection (j) shall not be used to offset or limit any appropriations made to the Service under the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, or any other provision of law.

(2) Funds which are appropriated pursuant to subsection (j) may be allocated to, or used for the benefit of, any Indian tribe which has a health resources deficiency level at level I or II only if a sufficient amount of funds have been appropriated pursuant to subsection (j) to raise all Indian tribes to health resources deficiency level II.

(3)(A) Funds appropriated pursuant to subsection (j) may be allocated on a service unit basis but must be used by each service unit (in accordance with paragraph (2)) to raise the deficiency level of each tribe served by such service unit.

(B) The apportionment of funds allocated to a service unit under subparagraph (A) among the health service responsibilities de-

scribed in subsection (a)(4) shall be determined by the Service and the affected Indian tribes.

(c)(1) For purposes of this section, the health resources deficiency levels of an Indian tribe are as follows:

(A) level I—0 to 20 percent deficiency;
(B) level II—21 to 40 percent deficiency;
(C) level III—41 to 60 percent deficiency;
(D) level IV—61 to 80 percent deficiency; and
(E) level V—81 to 100 percent deficiency.

(2) Under regulations, the Secretary shall establish procedures which allow any Indian tribe to petition the Secretary for a review of any determination of the health resources deficiency level of such tribe.

(d)(1) Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for funds appropriated pursuant to subsection (j) on an equal basis with programs that are administered directly by the Indian Health Service.

(2) If any funds allocated to a tribe or service unit under the authority of this section are used for a contract entered into under the Indian Self-Determination and Education Assistance Act, a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.

(e) The Secretary, acting through the service, shall expend directly or by contract, including contracts under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), not less than 1 percent of the funds appropriated pursuant to subsection (j) for research in the areas of health service responsibilities set out in subparagraphs (A) through (H) of subsection (a)(4).

(f) By no later than the date that is 60 days after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress the current health services priority system report of the Service for each Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

(1) the methodology for determining tribal health resources deficiencies;

(2) the level of health resources deficiency for each Indian tribe;

(3) the amount of funds necessary to raise all Indian tribes below health resources deficiency level II to health resources deficiency level II;

(4) the amount of funds necessary to raise all tribes below health resources deficiency level I to health resources deficiency level I;

(5) the amount of funds necessary to raise all tribes to zero health resources deficiency; and

(6) an estimate of—

(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, for the preceding fiscal year which is allocated to each service unit, Indian tribe, or comparable entity; and

(B) the number of Indians eligible for health services in each service unit or Indian tribe.

(g)(1) The Secretary, acting through the Service and in conjunction with each Indian tribe, shall annually update the tribal specific health plans which were developed as part of the plan required under section 703. The updating of such plans shall be carried out in accordance with the methodology submitted to the Congress under subsection (f), as modified through consultation with the Indian tribe to which such plan relates.

(2) The Secretary shall submit to Congress an annual report on the health services priority system of the Service by no later than 60 days after the date the President submits to the Congress the budget required under section 1105 of title 31, United States Code, for any fiscal year beginning after September 30, 1986. Such report shall be based on the updated tribal specific health plans described in paragraph (1).

(h)(1) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which—

(A) specifies the amount of funds requested to carry out the provisions of this section for such fiscal year, and

(B) specifies the total amount obligated or expended in the most recently completed fiscal year to carry out subsection (g) and to carry out each of the subparagraphs of subsection (a)(4).

(2) Funds appropriated under authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(i) Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve parity among Indian tribes.

(j) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $29,000,000 for fiscal year 1986,
(2) $28,000,000 for fiscal year 1987,
(3) $46,000,000 for fiscal year 1988, and
(4) $46,000,000 for ficsal year 1989.

Any funds approporiated under this subsection shall be designated as the "Indian Health Care Improvement Fund".

CATASTROPHIC HEALTH EMERGENCY FUND

SEC. 202. (a)(1) There is hereby established an Indian Catastrophic Health Emergency Fund (hereinafter in this section referred to as the "Fund") consisting of—

(A) the amounts deposited under subsection (d), and

(B) the amounts appropriated under subsection (e).

(2) The Fund shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses falling within the responsibility of the Service.

(3) The Fund shall not be allocated, apportioned, or delegated on a service unit, area office, or any other basis.

(4) No part of the Fund or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

(b) The Secretary shall, through the promulgation of regulations consistent with the provisions of this section—

(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the fund;

(2) provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until its cost of treating any victim of such catastrophic illness or disaster had reached a certain threshold cost which the Secretary shall establish at not less than $10,000 or not more than $20,000;

(3) establish a procedure for the reimbursement of the portion of the costs incurred by—

(A) service units or facilities, or

(B) whenever otherwise authorized by the Service, non-Service facilities or providers,

in rendering treatment that exceeds such threshold cost;

(4) establish a procedure for payment from the Fund in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

(5) establish a procedure that will assure that no payment shall be made from the Fund to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

(c) Funds appropriated under subsection (e) shall not be use to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, or any other law.

(d) There shall be deposited into the Fund—

(1) all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness falling within the responsibility of the Service, and

(2) all funds recovered under the authority of the Federal Medical Care Recovery Act (42 U.S.C. 2641 et seq.) by reason of such treatment.

(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $12,000,000 for fiscal year 1986, and

(2) for each of the fiscal years 1987, 1988, and 1989, such sums may be necessary to restore the Fund to a level of $12,000,000 for such fiscal year.

Funds appropriated under this subsection shall remain available until expended.

HEALTH PROMOTION AND DISEASE PREVENTION SERVICES

SEC. 203. (a) The Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians.

(b) The Secretary shall include in each health services priority system report which is required under section 201(g) an evaluation of—

(1) the health promotion and disease prevention needs of Indians identified in tribal specific health plans,

(2) the health promotion and disease prevention activities which would best meet such needs,

(3) the resources which would be required to enable the service to undertake the health promotion and disease prevention activities necessary to meet such needs, and

(4) the resources currently available to the Service which could be used to undertake such activities.

TITLE III--HEALTH FACILITIES

[SEC. 301. (a) The Secretary acting through the Service, is authorized to expend over the seven-fiscal-year period beginning after the date of the enactment of this Act the sums authorized by subsection (b) for the construction and renovation of hospitals, health centers, health stations, and other facilities of the Service.

[(b) The following amounts are authorized to be appropriated for purposes of subsection (a):

[(1) Hospitals: $67,180,000 for fiscal year 1978, $73,256,000 for fiscal year 1979, and $49,742,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for hospitals such sums as may be specifically authorized by an Act enacted after this Act.

[(2) Health centers and health stations: $6,960,000 for fiscal year 1978, $6,226,000 for fiscal year 1979, and $3,720,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for health centers and health stations such as may be specifically authorized by an Act enacted after this Act.

[(3) Staff housing: $1,242,000 for fiscal year 1978, $21,725,000 for fiscal year 1979, and $4,116,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for staff housing such sums as may be specifically be authorized by an Act enacted after this Act.

[(c) Prior to the expenditure of, or the making of any firm commitment to expend, any funds authorized in subsection (a), the Secretary, acting through the Service shall—

[(1) consult with any Indian tribe to be significantly affected by any such expenditure for the purpose of determining and, wherever practicable, honoring tribal preferences concerning the size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

[(2) be assured that, wherever practicable, such facility, not later than one year after its construction or renovation, shall meet the standards of the Joint Committee on Accreditation of Hospitals.

[CONSTRUCTION OF SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

[SEC. 302. (a) During the seven-fiscal-year period beginning after the date of the enactment of this Act, the Secretary is authorized to expend under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the sums authorized under subsection (b) to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

[(b) For expenditures of the Secretary authorized by subsection (a) for facilities in existing Indian homes and communities there are authorized to be appropriated $43,000,000 for fiscal year 1978, $30,000,000 for fiscal year 1979, and $30,000,000 for fiscal year 1980. For expenditures of the Secretary authorized by subsection (a) for facilities in new Indian homes and communities there are authorized to be appropriated such sums as may be necessary for fiscal years 1978, 1979, and 1980. For fiscal years 1981, 1982, 1983, and 1984 for expenditures authorized by subsection (a) there are authorized to be appropriated such sums as may be specifically authorized in an Act enacted after this Act.

[(c) Former and currently federally recognized Indian tribes in the State of New York shall be eligible for assistance under this section.]

CONSULTATION; CLOSURE OF FACILITIES

SEC. 301. (a) Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, acting through the Service, shall—

(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics on any facility on which such expenditure is to be made, and

(2) ensure, whenever practicable, that such facility meets the standards of the Joint Commission on Accreditation of Hospitals by not later than 1 year after the date on which the construction or renovation of such facility is completed.

(b)(1) Notwithstanding any other provisions of law, no Service hospital or other outpatient health care facility of the Service, or any portion of such a hospital or facility, may be close if the Secretary has not submitted to the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—

(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

(B) the cost effectiveness of such closure;

(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

(D) the availability of contract health care funds to maintain existing levels of service; and

(E) the views of the Indian tribes served by such hospital or facility concerning such closure.

(2) Paragraph (1) shall not apply to any temporary closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

(c) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each of the fiscal years 1987, 1988, and 1989, program information documents for the construction of 10 Indian health facilities which—

(1) comply with applicable construction standards, and

(2) have been approved by the Secretary.

(e)(1) The Secretary shall submit to the Congress an annual report which sets forth—

(A) the current health facility priority system of the Service,

(B) the planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority ambulatory care facilities (together with required staff quarters),

(C) the justification of such order of priority,

(D) the projected cost of such projects, and

(E) the methodology adopted by the Service in establishing priorities under its health facility priority system.

(2) The first report required under paragraph (1) shall be submitted by no later than the date that is 180 days after the date of enactment of the Indian Health Care Amendments of 1985 and, beginning in 1986, each subsequent annual report shall be submitted by the date that is 60 days after the date on which the President submits the budget to the Congress under section 1105 of title 31, United States Code.

(3) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall—

(A) consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any contract entered into with the Service under the Indian Self-Determination and Education Assistance Act, and

(B) review the needs of such tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

(4) For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any contract entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

(5) The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities which are the subject of contract for health services entered into with the Service under the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the development of the health facillity priority system.

SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. (a) The Congress hereby finds and declares that—

(1) the provision of safe water supply systems and sanitary sewage and solid waste disposal systems is primarily a health consideration and function;

(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such systems;

(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such systems and other preventive health measures;

(4) many Indian homes and communities still lack safe water supply systems and sanitary sewage and solid waste disposal systems; and

(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible.

(b)(1) In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

(2) The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

(A) financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities;

(B) ongoing technical assistance and training in the management of utility organizations which operate and maintain sanitation facilities; and

(C) operation and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities in situations in which the community, tribe, or family is not financially or technically capable of operating or maintaining the system, or of performing required emergency repair, with their own resources.

(c) Beginning in fiscal year 1986, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitation sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

(d) The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

(e) The provisions of this section shall not diminish the primary responsibility of the Indian family, community, or tribe to establish, collect, and utilize reasonable user fees, or otherwise set aside funding, for the purpose of operating and maintaining sanitation facilities.

(f) Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

(1) any funds appropriated pursuant to subsection (h), and

(2) any funds appropriated for the purpose of providing water supply or sewage disposal services,

on an equal basis with programs that are administered directly by the Indian Health Service.

(g)(1) The Secretary shall submit to the Congress an annual report which sets forth—

(A) the current Indian sanitation facility priority system of the Service;

(B) the methodology for determining sanitation deficiencies;

(C) the level of sanitation deficiency for each Indian tribe or community;

(D) the amount of funds necessary to raise all Indian tribes and communities to a level I sanitation deficiency; and

(E) the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.

(2) The first report required under paragraph (1) shall be submitted by no later than the date that is 180 days after the date of enactment of the Indian Health Care Amendments of 1985 and, beginning in 1986, each subsequent annual report shall be submitted by the date that is 60 days after the date on which the President submits the budget to the Congress under section 1105 of title 31, United States Code.

(3) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any contract entered into with the Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe.

(4) The methodology used by the Secretary in determining sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

(5) For purposes of this subsection, the sanitation deficiency levels for an Indian tribe or community are as follows:

(A) level I is an Indian tribe or community with a sanitation system—

(i) which complies with all applicable water supply and pollution control laws, and

(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs;

(B) level II is an Indian tribe or community with a sanitation system—

(i) which complies with all applicable water supply and pollution control laws, and

(ii) in which the deficiencies relate to capital improvements that are necessary to improve the facilities in order to meet the needs of such tribe or community for domestic sanitation facilities;

(C) level III is an Indian tribe or community with a sanitation system which—

(i) has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or

(ii) has no solid waste disposal facility;

(D) level IV is an Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system; and

(E) level V is an Indian tribe or community that lacks a safe water supply and a sewage disposal system.

(6) For purposes of this subsection, any Indian tribe or community that lacks the operation and maintenance capability to enable its sanitation system to meet pollution control laws may not be treated as having a level I or II sanitation deficiency.

(h)(1) There are authorized to be appropriated for each of the fiscal years 1986, 1987, 1988, and 1989, $5,000,000 for the purpose of providing funds necessary to implement the responsibilities of the Service described in subsection (b)(2).

(2) In addition to the amount authorized under paragraph (1), there are authorized to be appropriated for each of the fiscal years 1986, 1987, 1988, and 1989, $850,000 for the purpose of providing 30 new full-time equivalents for the Service which shall be used to carry out the responsibilities of the Service described in subsection (b)(2).

PREFERENCE TO INDIANS AND INDIAN FIRMS

SEC. 303. (a) The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as "Indian firm") in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless he finds, pursuant to rules and regulations promulgated by him, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at his finding, shall consider whether the Indian or Indian firm will be deficient with respect to (1) ownership and control by Indians, (2) equipment, (3) bookkeeping and accounting procedures, (4) substantive knowledge of the project or function to be contracted for, (5) adequately trained personnel, or (6) other necessary components of contract performance.

(b) For the purpose of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a-5, known as the Davis-Bacon Act).

SOBOBA SANITATION FACILITIES

SEC. 304. The Act of December 17, 1970 (84 Stat. 1465), is hereby amended by adding the following new section 9 at the end thereof:

"SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267)."

AUTHORIZATION

[SEC. 305. There are authorized to be appropriated to carry out sections 301 and 302 for the fiscal year ending September 30, 1981, for the fiscal year ending September 30, 1982, for the fiscal year ending September 30, 1983, and for the fiscal year ending September 30, 1984, such sums as may be necessary.]

EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION

SEC. 305. (a) Notwithstanding any other provision of law, the Secretary is authorized to accept any major renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination and Education Assistance Act, including—

(1) any plans or designs for such renovation or modernization, and

(2) any renovation or modernization for which funds appropriated under any Federal law were lawfully expended,

but only if the requirements of subsection (b) are met.

(b) The requirements of this subsection are met with respect to any renovation or modernization if the renovation or modernization—

(1) does not require to obligate the Secretary to provide any additional employees or equipment,

(2) is approved by the appropriated area director of the Service, and

(3) is administered by the Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of facilities.

(c) A renovation or modernization shall not be authorized by this section if such renovation or modernization would require the diversion of funds appropriated to the Service from any project which has a higher priority under the health facility priority system of the Service.

(d) If any Service facility which has been renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such renovation or modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such renovation or

modernization) bore to the value of such facility at the time of the completion of such renovation or modernization.

TITLE IV—ACCESS TO HEALTH SERVICES

ELIGIBLITY OF INDIAN HEALTH SERVICE FACILITIES UNDER MEDICARE PROGRAM

SEC. 401. (a) Sections 1814(c) and 1835(d) of the Social Security Act are each amended by striking out "No payment" and inserting in lieu thereof "Subject to section 1880, no payment".

(b) Part C of title XVIII of such Act is amended by adding at the end thereof the following new section:

"INDIAN HEALTH SERVICE FACILITIES

"SEC. 1880. (a) [A hospital or skilled nursing facility] *A provider of services or a rural health clinic* of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to [hospitals or skilled nursing facilities (as the case may be)] *facilities of that type* under this title.

"(b) Notwithstanding subsection (a) [a hospital or skilled nursing facility] *a provider of services or a rural health clinic* of the Indian Health service which does not meet all of the conditions and requirements of this title which are applicable, generally to [hospitals or skilled nursing facilities (as the case may be)] *facilities of that type,* but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

"(c) Notwithstanding any other provision of this title, payments to which [any hospital or skilled nursing facility] *any provider of services or rural health clinic* of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the [hospitals and skilled nursing facilities] *providers of services and rural health clinics* of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. *In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the providers and rural health clinics of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such providers and* *rural health clinics in order to achieve compliance with the conditions and requirements of this title.* [The preceding sentence] *This subsection* shall cease to apply when the Secretary determines and certifies that substantially all of the [hospitals and skilled nursing facilities] *providers of services and rural health clinics* of such Service in the United States are in compliance with such conditions and requirements.

(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a detailed statement of the status of the [hospitals and skilled nursing facilities] *providers of services and rural health clinics* of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such [hospitals and facilities] *providers of services and rural health clinics* (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.

(c) Any payments received for services provided to beneficiaries hereunder shall not be considered in determining appropriations for health care and services to Indians.

(d) Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in perference to an Indian beneficiary without such coverage.

SERVICES PROVIDED TO MEDICAID ELIGIBLE INDIANS

SEC. 402. (a) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"INDIAN HEALTH SERVICE FACILITIES

"SEC. 1911. (a) A facility of the Indian Health Service (including a hospital, intermediate care facility, or [skilled nursing ~~facility~~] *skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan),* whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

"(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, intermediate care facility, or [skilled nursing facility] *skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan)* which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.".

(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under the State plan.

(d) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) is entitled under a State plan approved under this title by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the facilities of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of this title. This subsection shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.

[(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under title XIX of the Social Security Act, as amended.

[(c) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) is entitled under a State plan approved under title XIX of the Social Security Act by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.]

(d) Any payments received for services provided recipients hereunder shall not be considered in determining appropriations for the provision of health care and services to Indians.

(e) Section 1905(b) of the Social Security Act is amended by inserting at the end thereof the following: "Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian

Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).".

REPORT

SEC. 403. The Secretary shall include in his annual report required by section 701 an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements through titles XVIII and XIX of the Social Security Act, as amended.

GRANTS TO AND CONTRACTS WITH TRIBAL ORGANIZATIONS

SEC. 404.(a) The Secretary, acting through the Service, shall make grants to or enter into contracts with tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

(1) enroll under section 1818 of part A and sections 1836 and 1837 of part B of title XVIII of the Social Security Act;

(2) pay monthly premiums for coverage due to financial need of such individual; **[**and**]** *or*

(3) apply for medical assistance provided pursuant to title XIX of the Social Security Act.

(b) The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any contract or grant which the Secretary makes with any tribal organization pursuant to this section. Such conditions **[**shall include, but are not limited to,**]** *may include, as appropriate,* requirements that the organization successfully undertake to—

(1) determine the population of Indians to be served that are or could be recipients of benefits under titles XVIII and XIX of the Social Security Act;

(2) assist individual Indians in becoming familiar with and utilizing such benefits;

(3) provide transportation to such individual Indians to the appropriate offices for enrollment or application for medical assistance;

(4) develop and implement a schedule of income levels to determine the extent of payment of premiums by such organization for coverage of needy individuals; and methods of improving the participation of Indians in receiving the benefits provided pursuant to titles XVIII and XIX of the Social Security Act.

[(c) There are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1981, $5,750,000 for the fiscal year ending September 30, 1982, $6,615,000 for the fiscal year ending September 30, 1983, and $7,610,000 for the fiscal year ending September 30, 1984.**]**

(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $1,500,000 for fiscal year 1986,

(2) $2,000,000 for fiscal year 1987,

(3) $500,000 for fiscal year 1988, and

(4) $500,000 for fiscal year 1989."

DEMONSTRATION PROGRAM FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

SEC. 405. (a) The Secretary shall establish a demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations, which are contracting the entire operation of an entire hospital or clinic of the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, shall directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (medicare), under a State plan for medical assistance approved under title XIX of the Social Security Act (medicaid), or from any other third-party payor. The Federal medical assistance percentage under the medicaid program shall continue to be 100 percent for purposes of the demonstration program.

(b)(1) Each hospital or clinic participating in the demonstration program described in subsection (a) shall be reimbursed directly under the medicare and medicaid program for services furnished, without regard to the provisions of sections 1880(c) and 1911(d) of the Social Security Act, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used—

(A) solely for improving the health resources deficiency level of the Indian tribe, and

(B) in accordance with the regulations of the Indian Health Service applicable to funds provided by the Indian Health Service under contract entered into under the Indian Self-Determination and Education Assistance Act.

(2) The amounts paid to the hospitals and clinics participating in the demonstration program described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Indian Health Service and to facilities participating in the medicare and medicaid programs.

(3) The Secretary shall monitor the performance of hospitals and clinics participating in the demonstration program described in subsection (a), and shall require such hospitals and clinics to submit reports on the program to the Secretary on a quarterly basis (or more frequently if the Secretary deems it to be necessary).

(4) Notwithstanding sections 1880(c) and 1911(d) of the Social Security Act, no payment may be made out of the special fund described in sections 1880(c) or 1911(d) of the Social Security Act for the benefit of any hospital or clinic which is participating in the demonstration program described in subsection (a).

(c)(1) In order to be considered for participation in the demonstration program described in subsection (a), a hospital or clinic must

submit an application to the Secretary which establishes to the satisfaction of the Secretary that—

(A) the Indian tribe or Alaska Native health organization contracts the entire operation of the Indian Health Service facility;

(B) the facility is eligible to participate in the medicare and medicaid programs under sections 1880 and 1911 of the Social Security Act;

(C) the facility meets any requirements which apply to programs operated directly the Indian Health Service; and

(D) the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan, which has been approved by the Secretary, for achieving such accreditation prior to October 1, 1987.

(2) From among the qualified applicants, the Secretary shall, prior to October 1, 1986, select no more than 4 facilities to participate in the demonstration program described in subsection (a). The demonstration program described in subsection (a) shall begin by no later than October 1, 1987, and end on September 30, 1992.

(d)(1) Upon the enactment of the Indian Health Care Amendments of 1985, the Secretary, acting through the Indian Health Service, shall commence an examination of—

(A) any administrative changes which may be necessary to allow direct billing and reimbursement under the demonstration program described in subsection (a), including any agreements with States which may be necessary to provide for such direct billing under the medicaid program; and

(B) any changes which may be necessary to enable participants in such demonstration program to provide to the Indian Health Service medical records information on patients served under such demonstration program which is consistent with the medical records information system of the service.

(2) Prior to the commencement of the demonstration program described in subsection (a), the Secretary shall implement all changes required as a result of the examinations conducted under paragraph (1).

(3) Prior to October 1, 1986, the Secretary shall determine any accounting information which a participant in the demonstration program described in subsection (a) would be required to report and shall provide funding for the development of any such accounting system by any facility which has been selected to participate in such demonstration program.

(e) The Secretary shall submit a final report at the end of fiscal year 1992, on the activities carried out under the demonstration program described in subsection (a) which shall include an evaluation of whether such activities have fulfilled the objectives of such program. In such report the Secretary shall provide a recommendation, based upon the results of such demonstration program, as to whether direct billing of, and reimbursement by, the medicare and medicaid programs and other third-party payors should be authorized for all Indian tribes and Alaska Native health organizations which are contracting the entire operation of a facility of the Indian Health Service.

(f) The Secretary shall provide for the retrocession of any contract entered into between a participant in the demonstration program described in subsection (a) and the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority shall be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.

STUDY OF BARRIERS TO PARTICIPATION

Sec. 406. (a) The Secretary shall, in consultation with Indian tribes and tribal organizations, conduct a study of any barriers which may exist to the participation of Indians in programs established under title XVIII of the Social Security Act (medicare) or under title XIX of the Social Security Act (medicaid).

(b) By no later than the date which is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

(1) recommendations for legislation which—
    (A) would remove any barriers to participation identified in such study, and
    (B) would encourage participation by Indians in the programs described in subsection (a); and
(2) estimates by service unit of—
    (A) the potential numbers of Indians eligible for medicare,
    (B) the potential number of Indians eligible for medcaid,
    (C) the number of Indians participating in the medicare program, and
    (D) the number of Indians participating in the medicaid program.

[TITLE V—HEALTH SERVICES FOR URBAN AND RURAL INDIANS

[PURPOSE

[Sec. 501. The purpose of this title is to encourage the establishment of programs in urban areas and rural communities to make health services more accessible to the urban and rural Indian population, respectively.

[CONTRACTS WITH URBAN AND RURAL INDIAN ORGANIZATIONS

[Sec. 502. The Secretary, acting through the Service, shall enter into contracts with urban Indian organizations and with rural Indian organizations to assist such organizations to establish and administer, in the urban centers or rural communities in which such organizations are situated, programs which meet the requirements set forth in sections 503 and 504.

[CONTRACT ELIGIBILITY

[SEC. 503. (a) The Secretary, acting through the Service, shall place such conditions as deemed necessary to effect the purpose of this title in any contract which the Secretary makes with any urban or rural Indian organization pursuant to this title. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

[(1) determine the population of urban or rural Indians which are or could be recipients of health referral or care services;

[(2) identify all public and private health service resources within the urban center or rural community in which the organization is situated which are or may be available to urban Indians or rural Indians, respectively;

[(3) assist such health services resources in providing service to such urban or rural Indians;

[(4) assist such urban or rural Indians in becoming familiar with and utilizing such resources;

[(5) provide basic health education to such urban or rural Indians;

[(6) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (3) through (5) of this subsection;

[(7) identify gaps between unmet health needs of urban Indians or rural Indians and the resources available to meet such needs;

[(8) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban or rural Indians; and

[(9) where necessary, provide or contracts for health care services to urban or rural Indians.

[(b) The Secretary, acting through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations and rural Indian organizations to enter into contracts pursuant to this title. Such criteria shall, among other factors, take into consideration—

[(1) the extent of the unmet health care needs of urban Indians in the urban center or of rural Indians in the rural community involved;

[(2) the size of the urban Indian population or the rural Indian community to receive assistance;

[(3) the relative accessibility of health care services to such population in such urban center or rural community;

[(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate any previous or current public or private health services project in such urban center or rural community that was or is funded in a manner other than pursuant to this title;

[(5) the appropriateness and likely effectiveness of the activities set forth in subsection (a) in such urban center or rural community;

[(6) the existence of an urban Indian organization or a rural Indian organization capable of performing the activities set forth in subsection (a) and entering into a contract with the Secretary pursuant to this title; and

[(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

[OTHER CONTRACT REQUIREMENTS

[SEC. 504. (a) Contracts with urban Indian organizations or rural Indian organizations pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (49 Stat. 793), as amended.

[(b) Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

[(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization or a rural Indian organization, revise or amend any contract made by the Secretary with such organization under this title as necessary to carry out the purposes of this title: *Provided, however,* That whenever an urban Indian organization or a rural Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

[(d) In connection with any contract made pursuant to this title, the Secretary may permit an urban Indian organization or a rural Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

[(e) Contracts with urban or rural Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban or rural Indians of services and assistance under such contracts by such organizations.

[REPORTS AND RECORDS

[SEC. 505. For each fiscal year during which an urban Indian organization or a rural Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a report including information gathered pursuant to section 503(a) (7) and (8), information on activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of the urban Indian organization or the rural Indian organization with respect to such contract shall be subject to audit by the Secretary and the Comptroller General of the United States.

[AUTHORIZATIONS

[SEC. 506. (a) There are authorized to be appropriated for contracts with urban Indian organizations under this title $18,750,000 for the fiscal year ending September 30, 1981, $21,500,000 for the fiscal year ending September 30, 1982, $24,725,000 for the fiscal year ending September 30, 1983, and $28,500,000 for the fiscal year ending September 30, 1984.

[(b) There are authorized to be appropriated for contracts with rural Indian organizations under this title $3,000,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, $3,000,000 for the fiscal year ending September 30, 1983, and $3,000,000 for the fiscal year ending September 30, 1984.

[REVIEW OF PROGRAM

[SEC. 507. Not later than the date six months after September 30, 1983, the Secretary, acting through the Service and with the assistance of the urban and rural Indian organizations that have entered into contracts under this title, shall review the program established under this title and submit to the Congress an assessment thereof and recommendations for any further legislative efforts the Secretary deems necessary to meet the purpose of this title.

[RURAL HEALTH PROJECTS

[SEC. 508. Not to exceed 1 per centum of the amounts authorized by section 506 shall be available for not to exceed two pilot projects providing outreach services to eligible Indians residing in rural communities near Indian reservations.]

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

PURPOSE

SEC. 501. The purpose of this title is to encourage the establishment of progams in urban centers to make health services more accessible to urban Indians.

CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

SEC. 502. Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts with urban Indian organizations to assist such organizations in the establishment and administration, within the urban centers in which such organizations are situated, of programs which meet the requirements set forth in this title. The Secretary, through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with any urban Indian organization pursuant to this title.

CONTRACTS FOR THE PROVISION OF HEALTH CARE OR REFERRAL SERVICES

SEC. 503. (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts with urban Indian organizations for the provision of health care or referral services for urban Indians residing in the urban centers in which such organizations are situated. Any such contract shall include requirements that the urban Indian organization successfully undertake to—

(1) determine the population of urban Indians residing in the urban center in which such organization is situated who are or could be recipients of health care or referral services;

(2) determine the current health status of urban Indians residing in such urban center;

(3) determine the current health care needs of urban Indians residing in such urban center;

(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

(5) determine the use of public and private health services resources by the urban Indians residing in such urban center;

(6) assist such health services resources in providing services to uran Indians;

(7) assist urban Indians in becoming familiar with and utilizing such health services resources;

(8) provide basic health education, including health promotion and disease prevention education, to urban Indians;

(9) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (6) through (8) of this subsection;

(10) identify gaps between unmet health needs of urbn Indians and the resources available to meet such needs;

(11) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

(12) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

(b) The Secretary, through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations to enter into contracts under this section. Such criteria shall, among other factors, include—

(1) the extent of unmet health care needs of urban Indians in the urban center involved;

(2) the size of the urban Indian population in the urban center involved;

(3) the accessibility to, and utilization of, health care services (other than services provided under this title) by urban Indians in the urban center involved;

(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate—

(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this title; or

(B) any project funded under this title;

(5) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary under this section;

(6) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

(7) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center; and

(8) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

CONTRACTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS

SEC. 504. (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, may enter into contracts with urban Indian organizations situated in urban centers for which contracts have not been entered into under section 503. The purpose of a contract under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract under section 503 with the urban Indian organization with which the Secretary has entered into a contract under this section.

(b) Any contract entered into by the Secretary under this section shall include requirements that—

(1) the urban Indian organization successfully undertake to—

(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

(B) with respect to urban Indians in the urban center involved, determine the matters described in clauses (2), (3), (4), and (8) of section 503(b); and

(2) the urban Indian organization complete performance of the contract within one year after the date on which the Secretary and such organization enter into such contract.

(c) The Secretary may not renew any contract entered into under this section.

EVALUATIONS; CONTRACT RENEWALS

SEC. 505. (a) The Secretary, through the Service, shall develop procedures to evaluate compliance with, and performance of, contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

(b) The Secretary, through the Service, shall conduct an annual onsite evaluation of each urban Indian organization which has entered into a contract under section 503 for purposes of determining

the compliance of such organization with, and evaluating the performance of such organization under, such contract.

(c) If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract with such organization and is authorized to enter into a contract under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract is not renewed under this section.

(d) In determining whether to renew a contract with an urban Indian organization under section 503, or whether to enter into a contract with an urban Indian organization under section 503 which has completed performance of a contract under section 504, the Secretary shall review the records of the urban organization, the reports submitted under section 507, and, in the case of a renewal of a contract under section 503, shall consider the results of the on-site evaluation conducted under subsection (b).

OTHER CONTRACT REQUIREMENTS

SEC. 506. (a) Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935, as amended.

(b) Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title, except that whenever an urban Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

(d) In connection with any contract entered into pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

(e) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts by such organizations.

REPORTS AND RECORDS

SEC. 507. (a) For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into pursuant to this title, such organization shall submit to the Secretary a quarterly report including—

(1) in the case of a contract under section 503, information gathered pursuant to clauses (10) and (11) of subsection (a) of such section;

(2) information on activities conducted by the organization pursuant to the contract;

(3) an accounting of the amounts and purposes for which Federal funds were expended; and

(4) such other information as the Secretary may request.

(b) The reports and records of the urban Indian organization with respect to a contract under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

(c) The Secretary shall allow as a cost of any contract entered into under section 503 the cost of an annual private audit conducted by a certified public accountant.

LIMITATION ON CONTRACT AUTHORITY

SEC. 508. The authority of the Secretary to enter into contracts under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

[TITLE VI—AMERICAN INDIAN SCHOOL OF MEDICINE; FEASIBILITY STUDY

[FEASIBILITY STUDY

[SEC. 601. The Secretary, in consultation with Indian tribes and appropriate Indian organizations, shall conduct a study to determine the need for, and the feasibility of, establishing a school of medicine to train Indians to provide health services for Indians. Within one year of the date of the enactment of this Act the Secretary shall complete such study and shall report to the Congress findings and recommendations based on such study.]

TITLE VI—INDIAN HEALTH SERVICE

ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

SEC. 601. (a)(1) In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as is or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service.

(2) The Indian Health Service shall be administered by a Director who shall be appointed by the President by and with the advice and consent of the Senate. The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary of Health and Human Services for Health and shall not report to, or be under the supervision of, any other officer or employee of the Department of Health and Human Services.

(b) The Indian Health Service shall be an agency within the Public Health Service of the Department of Health and Human Services, and shall not be an office, component, or unit of any other agency of the Department.

(c) The Secretary shall carry out through the Director of the Indian Health Service—

(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1985, carried out by, or under the direction of, the individual serving as Director of the Indian Health Service on such day;

(2) all functions of the Secretary or the Department of Health and Human Services relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and the provision and utilization of, health services for Indians; and

(3) all health programs under which health care is provided to Indians based upon their status as Indians that are administered by the Secretary, including (but not limited to) programs under—

(A) this Act;

(B) the Act of November 2, 1921 (25 U.S.C. 13);

(C) the Act of August 5, 1984 (68 Stat. 674);

(D) the Act of August 16, 1957 (71 Stat. 370); and

(E) the Indian Self-Determination and Education Assistanced Act.

(d)(1) Notwithstanding any other provision of law, the Indian Health Service shall not be reorganized, altered, or discontinued and any function which is specifically assigned by this section to the Director of the Indian Health Service or to the Secretary of Health and Human Services through the Director of the Indian Health Service shall not be allocated, reallocated, transferred, or delegated to any officer or employee of the Federal Government who is not within the Indian Health Service.

(2) Paragraph (1) shall not apply to any action taken by the Director of the Indian Health Service which the Director of the Indian Health Service determines to be appropriate.

(e)(1) The Director of the Indian Health Service shall have the authority—

(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

(b) to enter into contracts for the procurement of goods and services to carry out the functions of the Service and;

(C) to manage, expend, and obligate all funds appropriated for the Service.

(2) The authority of the Director of the Indian Health Service to enter into contracts under this subsection shall be to such extent, and in such amounts, as are provided in appropriation Acts.

MANAGEMENT INFORMATION SYSTEM; ACCESS TO PATIENT'S RECORDS

SEC. 602. (a)(1) The Secretary shall establish an automated management information system for the Service.

(2) The information system established under paragraph (1) shall include—

(A) a financial management system.

(B) a patient care information system for each area served by the Service,

(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service, and

(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each Area office of the Service.

(3) By no later than September 30, 1986, the Secretary shall submit a report to Congress setting forth—

(A) the activities which have been undertaken to establish an automated management information system,

(B) the activities, if any, which remain to be undertaken to complete the implementation of an automated management information system, and

(C) the amount of funds which will be needed to complete the implementation of a management information system in the succeeding fiscal years.

(b) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

TITLE VII—MISCELLANEOUS

SEC. 701. The Secretary shall report annually to the President and the Congress on progress made in effecting the purposes of this Act. Within three months after the end of fiscal year 1979, the Secretary shall review expenditures and progress made under this Act and make recommendations to the Congress concerning any additional authorizations for fiscal years 1981 through 1984 for programs authorized under this Act which he deems appropriate. In the event the Congress enacts legislation authorizing appropriations for programs under this Act for fiscal years 1981 thorough 1984, within three months after the end of fiscal year 1983, the Secretary shall review programs established or assisted pursuant to this Act and shall submit to the Congress his assesement and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and insure a health status for Indians, which are at a parity with the health services available to, and the health status, of the general population.

REGULATIONS

SEC. 702. (a)(1) Within six months from the date of enactment of this Act, the Secretary shall, to the extent practicable, consult with national and regional Indian organizations to consider and formulate appropriate rules and regulations to implement the provisions of this Act.

(2) Within eight months from the date of enactment of this Act, the Secretary shall publish proposed rules and regulations in the Federal Register for the purpose of receiving comments from interested parties.

(3) Within ten months from the date of enactment of this Act, the Secretary shall promulgate rules and regulations to implement the provisions of the Act.

(b) The Secretary is authorized to revise and amend any rules or regulations promulgated pursuant to the Act: *Provided,* That, prior to any revision of or amendment to such rules or regulations, the Secretary shall to the extent practicable, consult with appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.

PLAN OF IMPLEMENTATION

SEC. 703. Within two hundred and forty days after enactment of this Act, a plan will be prepared by the Secretary and will be submitted to the Congress. The plan will explain the manner and schedule (including a schedule of appropriation requests), by title and section, by which the Secretary will implement the provisions of this Act.

LEASES WITH INDIAN TRIBES

SEC. 704. Notwithstanding any other provisions of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes for periods not in excess of twenty years.

Property leased by the Secretary from an Indian tribe may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe.

AVAILABILITY OF FUNDS

SEC. 705. The funds appropriated pursuant to this Act shall remain available until expended.

[RESOURCE ALLOCATION PLAN

[SEC. 706. Within one year from the date of the enactment of this section, the Secretary shall submit to the Congress a resource allocation plan. Such plan shall explain the future allocation of services and funds among the service population of the Service and shall provide a schedule for reducing deficiencies in resources of tribes nontribal specific entities.]

JUVENILE ALCOHOL AND DRUG ABUSE

SEC. 706. (a) Within 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall enter into an agreement with the Secretary of the Interior and the Secretary of the Education to coordinate the effort of their Departments related to alcohol and drug abuse among Indian juveniles. The agreement shall provide for the identification and coodination of available resources and programs to combat Indian juvenile alcohol and drug abuse through prevention, education, counsel, and referral. The Secretary shall publish such agreement in the Federal Register within 18 months after the date of enactment of the Indian Health Care Amendments of 1985.

(b)(1) The Secretary, acting through the Service and in consultation and cooperation with the Secretary of the Interior and the Secretary of Education, shall develop a program to provide training in—

(A) health promotion and disease prevention education;

(B) the prevention of alcohol and drug abuse;

(C) the identification of juvenile alcohol and drug abusers; and

(D) counseling techniques on juvenile alcohol and drug abuse.

(2) The training program developed under paragraph (1) shall be provided to elementary and secondary teachers and counselors—

(A) in schools operated by the Bureau of Indian Affairs;

(B) in schools operated under contract with the Bureau of Indian Affairs; and

(C) in public schools on or near Indian reservations (including public schools in Oklahoma and Alaska with significant numbers of Indian students).

The Service may provide such training either directly or through contract with qualified private or public entities.

(c) The Secretary of the Interior, acting through the Bureau of Indian Affairs and in consultation with the Service, shall review existing literature and reports on juvenile alcohol and drug abuse, including studies and school curricula and any other material relevant to an understanding of the problem of juvenile alcohol and drug abuse and shall make available the results of such review to the schools described in subsection (b)(2).

(d) There are authorized to be appropriated for each of the fiscal years 1986, 1987, 1988, and 1989, such sums as may be necessary to carry out the provisions of subsection (b).

NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

SEC. 707. ⟦(a) The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and organizations, a study of the health hazards to Indian miners and Indians on or near Indian reservations and in Indian communities as a result of nuclear resources development. Such study shall include—

⟦(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

[(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

[(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplant operation and construction, and nuclear waste disposal;

[(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations and inspections during the five years prior to the date of the enactment of this section that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

[(5) the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such nuclear resource development.

(b) Upon completion of such study the Secretary and the Service shall take into account the results of such study and develop a health care plan to address the health problems studied under subsection (a). The plan shall include—

[(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

[(2) preventive care for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other nuclear development activities that have had or could have a serious impact upon the health of such individuals; and

[(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear development activities, may experience health problems.]

(a) The Secretary, acting through the Service, shall enter into appropriate arrangements with the National Academy of Sciences, in consultation with the Office of Technology Assessment, to conduct a study of the health hazards to Indian miners and to Indians living on, or near Indian reservations or in Indian communities which result from development of nuclear resources. Such study shall include—

(1) an evaluation of the nature and extent of nuclear-resource-development-related health problems currently exhibited among Indians and the causes of such health problems;

(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplant operation and construction, and nuclear waste disposal;

(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and in-

spections during the 10-year period ending on the date of enactment of the Indian Health Care Amendments of 1985 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

(5) an evaluation of the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of nuclear resource development.

To assist the Academy in conducting such study, the Secretary and the Secretary of the Interior shall furnish at the request of the academy any information which the Academy deems necessary for the purpose of conducting the study. In addition, they shall cooperate with the academy in obtaining information necessary to carry out the intent of the study.

(b) Upon the completion of the study described in subsection (a), the Secretary, acting through the service, shall develop, on the basis of the results of such study, a health care plan to address the health problems studied under subsection (a). The plan shall include—

(1) methods for diagnosing and treating Indians currently exhibiting nuclear-resource-development-related health problems;

(2) provision of preventive care for Indians who may be exposed to such health hazards as a result of nuclear resource development, including the monitoring of the health of individuals who have been, or may have been, exposed to excessive amounts of radiation, or otherwise affected by nuclear development activities that have had or could have a serious impact upon the health of such individuals; and

(3) a program of education for Indians who, by reason of their work or geographic proximity to nuclear development activities, may experience health problems.

(c) The Secretary and the Service shall submit to Congress the study prepared under subsection (a) [no later than the date eighteen months after the date of enactment of this section.] *by no later than the date which is 18 months after the date of enactment of the Indian Health Care Amendments of 1985.* The health care plan prepared under subsection (b) shall be submitted in a report no later than the date one year after the date that the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

(d)(1) There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees): the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Director of the Bureau of Mines, the Assistant Secretary for Occupational Safety and Health, and the Secretary of the Interior.

"(2) The Task Force shall identify existing and potential operations related to nuclear resource development that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community and enter into activities to correct existing health hazards and insure that current and future health problems resulting from nuclear resource development activities are minimized or reduced.

(3) The Secretary shall be Chairman of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

(e) In the case of any Indian who—

(1) as a result of employment in or near a uranium mine or mill, suffers from a work related illness or condition;

(2) is eligible to receive diagnosis and treatment services from a Service facility; and

(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator;

the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator from such operator. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.

[(f) There is authorized to be appropriated $300,000 to carry out the study as provided in subsection (a), such amount to be expended by the date eighteen months after the date of the enactment of this section.]

(f) There are authorized to be appropriated $750,000 for the purpose of conducting the study described in subsection (a). Such funds shall remain available for expenditure until the date which is 18 months after the date such funds are appropriated.

ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 708. (a) For the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, [1984] *1989,* the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to [Indians in such State] *members of federally recognized Indian tribes of Arizona.*

(b) The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

[(c) There are authorized to be appropriated to carry out this section $2,000,000 for the fiscal year ending September 30, 1982, $2,000,000 for the fiscal year ending September 30, 1983, and $2,000,000 for the fiscal year ending September 30, 1984.]

(c) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section

[CALIFORNIA FORMER FEDERALLY RECOGNIZED TRIBES

[SEC. 709. Indians in the State of California who are members or descendants of members of former federally recognized tribes of the State of California shall be eligible for services from the Service in the fiscal years beginning with the fiscal year ending September

30, 1982, and ending with the fiscal year ending September 30, 1984.]

ELIGIBILITY OF CALIFORNIA INDIANS

SEC. 709. The following California Indians shall be eligible for care from the Service:

(1) Any Member of a federally recognized Indian tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

(A) is living in California,

(B) is a member of the Indian community served by a local program of the Service, and

(C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

Paragraph (4) shall not apply after September 30, 1988.

[*PERSONNEL CEILINGS DEMONSTRATION PROJECT*

[SEC. 710. (a) In order to determine whether the Service can be better managed through fiscal controls without personnel ceilings, the Service shall, in conjunction with the Office of Personnel Management and the Secretary, conduct a demonstration project in which certain personnel ceilings in the Service are lifted. Such demonstration project shall be conducted in two of the Indian Health Service areas and shall be closely monitored by the Service.

[(b) Not later than the date 2 years after the date of the enactment of this section, the Service shall submit a report to Congress regarding the demonstration project carried out under subsection (a). Such report shall include a discussion of whether the lifting of personnel ceilings would improve the Service's ability to deliver services, what potential negative impact the lifting of personnel ceilings might have on the control of Federal employment, and a determination as to whether the lifting of personnel ceilings should be expanded to the entire Service.]

CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 710. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State.

CONTRACT HEALTH FACILITIES

SEC. 711. The Indian Health Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Indian Health Service entered into under the Indian Self-Determination Act—

(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,

(2) for empolyee training,

(3) for cost-of-living increases for employees, and

(4) for any other expenses relating to the provision of health services,

on the same basis as such funds are provided to programs and facilities operated directly by the Indian Health Service.

NATIONAL HEALTH SERVICE CORPS

SEC. 712. The Secretary of Health and Human Services may remove a member of the National Health Service Corps from a health facility operated by a tribe or tribal organization under a contract with the Service entered into under the Indian Self-Determination Act only if—

(1) the Secretary has provided written notice of such removal or withdrawal to such tribe or tribal organization at least 60 days before the date on which such contract was entered into or renewed, and

(2) the Secretary provides such funds or other personnel as may be necessary to ensure that the Indians who receive services from such member will not experience a reduction in services.

SERVICE TO INELIGIBLE PERSONS

SEC. 713. (a)(1) The Secretary, acting through the Service, may provide or authorize the provision of medical care, treatment, or benefits by the Service to persons who are not otherwise eligible for such services in health facilities maintained by the Service or contracted under the Indian Self-Determination and Education Assistance Act (Public Law 93-638) or thraough contract health care services, subject to the limitations of this section.

(2) Any individual who—

(A) has not attained 19 years of age,

(B) is the natural or adopted child (including foster- and stepchild), legal ward, or orphan of an eligible Indian, and

(C) is not otherwise eligible for the medical care, treatment, or benefits of the Service,

shall be eligible for all such services on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential medical needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

(3) Non-Indian spouses of eligible Indians and spouses of Indian descent who are not otherwise eligible for the medical care, treatment, or benefits of the Service shall not be eligible for such service unless they are made eligible, as a class, by an appropriate resolution of the governing body of the relevant Indian tribe. The medical needs of persons made eligible under this subsection shall not be

taken into consideration by the Service in determining the need for, or allocation of, its health resources.

(b)(1)(A) Upon the request of the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) included within the service area of any service unit of the Service, the Secretary may authorize the medical care and treatment of otherwise ineligible persons residing within such service area in health facilities maintained and operated by the Service.

(B) Persons receiving medical care and treatment by reason of this subsection shall be liable for the payment for such services under a fee schedule adopted by the Secretary which, in the judgment of the Secretary, shall result in reimbursement in an amount not less than the actual cost of providing the service. Fees collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility.

(2)(A) Expect as provided in subparagraph (B), if the governing body of any Indian tribe revokes its concurrence to the provision of services under paragraph (1)(A), the Secretary's authority to provide such service shall terminate at the end of the fiscal year following the fiscal year in which such revocation was adopted.

(B) In California, in the case of a multi-tribal service area, unless 51 percent or more of the Indian tribes in the Service area revoke their concurrence to the provision of services under paragraph (1)(A), the authority to provide such service shall not be affected.

(3)(A) In the case of health facilities operated directly by the Service, medical care and treatment may be provided to individuals under this subsection only if the Secretary and the affected tribe or tribes have jointly determined that—

(i) the provisions of such service will not result in a denial or diminution of service to eligible Indians, and

(ii) there is no reasonable altenative health facility or service, within or without the service unit area, available to meet the medical needs of such individuals.

(B) In the case of health facilities operated under a contract entered into under the Indian Self-Determination and Education Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under such contract is authorization providing health services under such contract is authorized to determine the eligibility for such health services of individuals who are not otherwise eligible for such health services. Such determination shall be in accordance with the requirements of this section.

(c) The Service may continue to provide medical care, treatment, and benefits to individuals not provided services under subsections (a) or (b) in order to—

(1) achieve stability in a medical emergency,

(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard,

(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum, or

(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

(d) Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination and Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners shall not be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) even if such practitioners provide services to eligible persons as a part of the conditions under which such hospital privileges are extended.

INFANT AND MATERNAL MORTALITY; FETAL ALCOHOL SYNDROME

SEC. 714 (a) By not later than January 1, 1987, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1991:

(1) reduction of the rate of Indian infant mortality in each area office of the Service to the lower of—

(A) twelve deaths per one thousand live births, or

(B) the rate of infant mortality applicable to the United States population as a whole;

(2) reduction of the rate of maternal mortality in each area office of the Service to the lower of—

(A) five deaths per one hundred thousand live births, or

(B) the rate of maternal mortality applicable to the United States population as a whole; and

(3) reduction of the rate of fetal alcohol syndrome and fetal alcohol effects associated with maternal consumption of alcohol to the lower of—

(A) one per one thousand live births, or

(B) the rate of fetal alcohol syndrome and such fetal alcohol effects applicable to the United States population as a whole.

(b) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in subsection (a).

REDUCTION AND CONTROL OF HEPATITIS–B IN ALASKA

SEC. 715. (a)(1) By no later than the date that is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary, through the Service and in conjunction with the State of Alaska and the Centers for Disease Control of the Department of Health and Human Services, shall complete the implementation of a program to provide for—

(A) screening and reporting of cases of,

(B) vaccinations for the prevention of, and

(C) control of the incidence of, hepatitis–B in Alaska.

(2) By no later than December 31, 1987, the Secretary shall submit to the Congress a report concerning the activities carried out under the program described in paragraph (1). The report shall include—

(A) a description of any activities which, on the day the report is submitted, need to be carried out to control the incidence of hepatitis-B in Alaska, and

(B) a schedule for the completion of such activities.

(b) The President shall include in the budget submitted under section 1105(a) of title 31, United States Code, for each of the fiscal years succeeding the fiscal year in which the Indian Health Care Amendments of 1985 are enacted, a request for budget authority for, and estimates of outlays for, a program to control the incidence of hepatitis-B in Alaska.

SHARING OF RESOURCES BETWEEN THE SERVICE AND THE VETERANS' ADMINISTRATION

SEC. 716. (a) The Secretary shall examine the feasibility of entering into an arrangement with the Administrator of the Veterans' Administration pursuant to the authority of subchapter IV of chapter 81 of title 38, United States Code, for the sharing of medical resources and services between the Indian Health Service and the Veterans' Administration.

(b) The Secretary shall submit a report on the findings made under subsection (a) to the Administrator of the Veterans' Administration who shall include such report with the report that the Administrator or the Veterans' Administration is required to submit under section 5057 of title 38, United States Code.

(c) In carrying out the provisions of this section, the Secretary shall take no action nor make any recommendation which would impair—

(1) the entitlement of any Indian to receive health services, as an Indian, through the Indian Health Service, or

(2) the entitlement of any Indian who is a veteran to receive health services, as a veteran, through the Verterans' Administration.

CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

SEC. 717. The Secretary, acting through the Service, as directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

STUDY OF HEALTH CARE NEEDS OF NATIVE HAWAIIANS AND OTHER NATIVE PACIFIC ISLANDERS

SEC. 718. (a)(1) The Secretary shall conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders.

(2) In conducting the study required under paragraph (1), the Secretary shall consult with the Commissioner of the Administration for Native Americans, the Administrator of the Alcohol, Drug

Abuse, and Mental Health Administration, the Director of the Indian Health Service, leaders in the field of health care, and representatives of Native Hawaiians and other Native American Pacific Islanders.

(b) By no later than the date that is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

(1) an assessment of the access of, and barriers to, Native Hawaiians and other Native American Pacific Islanders in receiving physical and mental health care services,

(2) an assessment of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders, and

(3) specific recommendations for the development of a national strategy to address such needs.

DEMONSTRATION PROJECT FOR NATIVE HAWAIIAN HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 719. (a) The Secretary shall establish in Hawaii, as a demonstration project, a Native Hawaiian Program for Health Promotion and Disease Prevention (hereinafter in this section referred to as the 'Program') for the purpose of exploring ways to meet the unique health care needs of Native Hawaiians.

(b)(1) The Program shall—

(A) provide necessary preventive-oriented health services, including health education and mental health care;

(B) develop innovative training and research projects;

(C) establish cooperative relationships with the leadership of the Native Hawaiian community; and

(D) ensure that a continuous effort is made to establish programs which can be of direct benefit to other Native American people.

(2) The Secretary is authorized to enter into contracts with—

(A) Native Hawaiian organizations recognized by the Governor of Hawaii, and

(B) institutions which serve the needs of Native Hawaiians,

for the purpose of assisting the Program in meeting the objectives described in paragraph (1).

(c) The Secretary shall submit to the Congress an annual report for each of the fiscal years 1986, 1987, and 1988 on the status and accomplishments of the Program during such fiscal year.

(d) There are authorized to be appropriated $500,000 for each of the fiscal years 1986, 1987, and 1988, for the purpose of carrying out the provisions of this section.

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